CM - CAH

DR. MURPHY

Title	Surname (Block letters)	First Names	Hospital No.
MST	MITCHELL	CONOR	B639929

DECEASED: 12.5.03

CRAIGAVON AREA

CONFIDENTIAL

2003

B639929

Hospital No.

088-004-032

1/5/3
4.45pm.
CAH(ICU)

TRANSFER LETTER.

RE: CAHB63929 12/10/1987
A69
MST CONOR MITCHELL
[redacted]

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

DEAR, DR CHISAKUTA;

THANKYOU FOR ACCEPTING THIS (15) CHILD WITH CEREBRAL PALSY AND EPILEPSY FOR FURTHER ICU CARE.

HE WAS ADMITTED TO CAH A&E DEPARTMENT ON 8/5/3 WITH A 10 DAY HISTORY OF ~~GENERALLY~~ MALAISE, VOMITING AND A FAILURE OF RESPONSE TO G.P. PRESCRIBED ANTIBIOTICS.

HE WAS ASSESSED TO BE CLINICALLY DEHYDRATED AT THAT TIME AND ~~HE~~ WAS TRANSFERRED TO ADULT MEDICAL CARE DUE TO HIS ABSENCE OF ABDOMINAL FINDINGS AND HIS AGE. (16. >15YRS)

SHORTLY AFTER ARRIVING ON THE WARD, HE SUFFERED A NUMBER OF SEIZURES. (THESE HAVE BEEN DESCRIBED AS MUCH MORE SEVERE THAN HIS PAST HISTORY OF PETIT MAL SEIZURES) HE PROCEEDED TO RESPIRATORY ARREST AND WAS REVIVED AND INTUBATED BY CAH ICU TEAM. AND TRANSFERRED TO ICU CARE.

OVERNIGHT HIS GCS WAS 3/15 AND HE WAS ASSESSED FOR [illegible] RESPONSES. THEY WERE HALTED DUE TO NEUROLOGICAL +VE RESPONSES TO MOVEMENT.

A CT-SCAN PERFORMED LAST NIGHT THE IMPRESSION OF A SMALL SUBDURAL BLEED. THIS WAS DISCUSSED c̄ NEURORADIOLOGY WHO HAVE STATED THAT IT WOULD NOT REQUIRE SURGICAL INTERVENTION.

PRESENT OBSERVATIONS FiO2 = 30%
TUBE SIZE ~ 6.5 ~~cm~~ OF SIMV - PEEP PRESSURE SUPPORT 5cm.
(R) FEMORAL LINE - TRIPLE LUMEN - 7 French
CVP - 7 LINE (L) BRACHIAL ART LINE.
CATHETER IN SITU.

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: [redacted]
Text Phone Number: [redacted]

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

9/5/03

Toni

– Thanks a million

[signature]

Current Meds

Adrenaline 8mg/100mls 3mls/hr.
Ciprofloxacin 200mg IV Bd.
Acyclovir 250mg IV 8°
Enoxaparin 20mg S/C.

? Allergy to Penicillin.

BP = 100/55
PR = 75/min
SATS = 98%
CVP = 10.
Temp = 36.

Blood Gas –
pH = 7.42. SATS = 99.4.
pCO_2 = 4.3
pO_2 = 18.2
Bicarb – 22.4
BE = -3.1

[signature] /1/03
Sr

Headquarters:
Craigavon Area Hospital Group HSS Trust
Craigavon, BT63 5QQ
Tel: [redacted]
Text Phone Number: [redacted]

CRAIGAVON AREA HOSPITAL

HOSPITAL NUMBER 1-3: 3 1 4

NAME: MITCHELL CONOR

UNIT NUMBER 4-13: [redacted]

ADDRESS: [redacted] 14-15: [redacted]

BIRTH SURNAME

SEX M - MALE F - FEMALE 16: M

DATE OF BIRTH 17-22: 1 3 1 0 8 2

OCCUPATION

Note: Where patient is a 'child', 'at school' or a 'housewife' please state occupation of head of household

NK 23:

MARITAL STATUS 24: 1

1 - Single 2 - Married 3 - Widowed 4 - Other 5 - Not Known

RELIGION 25: [redacted]

1 - Church of Ireland 2 - Presbyterian 3 - Methodist 4 - Roman Catholic 5 - Jewish 6 - Other (specify) 7 - Not Known 9 - None

DATE OF ADMISSION 26-31: 0 8 0 5 0 3

ADMISSION TYPE 32: 1

1 - Immediate 2 - Waiting List 3 - Other Hospital 4 - Booked (Non Maternity) 5 - Booked (Maternity) 6 - Born in Hospital

DATE PLACED ON WAITING LIST OR BOOKED (NON MATERNITY) 33-38:

ACCIDENT 39: 1 4

1 - Home burns 2 - Home - Scalds 3 - Home - Falls 4 - Home Poisoning - Inhalation 5 - Home poisoning - Other 6 - Home - Other 7 - RTA 8 - School 9 - At Work 10 - Sport 11 - Civil Disturbance 12 - Assault 13 - Other 14 - Not Applicable

CONSULTANT DR P MURPHY 40-43: 5 2 1 2

NO. OF FORM IN BATCH 44-46:

OWN DOCTOR

DR WILSON

[redacted]

TELEPHONE: [redacted]

RELATIVE OR OTHER PERSON FOR CONTACT IN EMERGENCY

MISS JOANNA MITCHELL

[redacted]

TELEPHONE: MOTHER [redacted]

PREVIOUS ATTENDANCES YES/NO

WARD MOH

ADMITTED BY BLY

TIME 12.21

3263

WMM 035 C

Venous
Cover
Mitchell. B2

RapidPoint400

ARTERIAL SAMPLE
08.05.2003 10:59
System Name A-E
System ID 0401-03677

ACID BASE 37.0 °C

pH	7.415	
pCO_2	4.99	kPa
pO_2	3.96↓	kPa
HCO_3^-act	23.5	mmol/L
HCO_3^-std	23.0	mmol/L
BE(B)	-0.7	mmol/L
BE(ecf)	-1.1	mmol/L
$ctCO_2$	24.7	mmol/L

OXYGEN STATUS 37.0 °C

Hct	0.41	
ctHb(est)	13.9	g/dL
O_2SAT(est)	57.8	%

ELECTROLYTES

Na^+	135.7	mmol/L
K^+	3.06↓	mmol/L
Ca^{++}	0.89↓	mmol/L
Ca^{++}(7.4)	0.90	mmol/L
Cl^-	97	mmol/L
AnGap	18.3	mmol/L

METABOLITES

Glu	7.7↑	mmol/L

PATIENT RANGES

pH	7.350 - 7.450
pCO_2	4.50 - 6.50
pO_2	10.00 - 15.00
Na^+	133.0 - 146.0
K^+	3.50 - 4.50
Ca^{++}	1.05 - 1.30
Cl^-	96 - 106
Glu	3.6 - 5.5
Hct	0.37 - 0.54

HISTORY AND PHYSICAL EXAMINATION

C.A. Ia

Date of Admission	Hospital	Age
8/5/03		15
Consultant		Ward No.
Dr Murphy		MAU

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward' Dept. Address

Conor Mitchell

Present History

P/C - Vomiting / ↓ oral intake

HPC - Hx central palsy
- 10/7 hx lethargy / ↓ oral intake.
- Commenced on penicillin for ear/throat infection - improved, then started vomiting
- Vomiting settled 3/7 ago - Able to keep down some food + fluids
- Mother noticed sediment in urine 2/7 ago - strong smelling urine
- Spasms increasing over past 1/52 - Seems to be in pain
- No cough / sputum
- Occ absence seizures - On Epilim

SHx - Lives with mother / grandmother
-

IF SPACE INADEQUATE CONTINUE OVERLEAF

Previous History	Drug Therapy at time of Admission
DM (Asthma)	Epilim 200mg tid
	(Check direct with family doctor)
Family History	**Drug Sensitivities**
—	Vomiting with penicillin

This Information must immediately be written on the Prescription sheet and in the appropriate section of the inside of the front cover. PT423

PHYSICAL EXAMINATION

OE Drowsy, Pale
Flexion contractures both arms
Temp 36.7° Sats 97% RA
BP 118/69

Chest – Clear

CVS – Pulse 72 Reg
HS I + II + O

Abdom – Thin
Soft Nontender ? masses BS ✓

Imp – UTI

Plan – FBP / U&E / CRP / Bl cultures
– IV fluids
– IV Ciproxin – 10 mg/kg tid.
– MSU
– Analgesia PR
– CXR / AXR

urinalysis – + protein + blood large ketones

Hb 13.6 Gluc 7
WCC 19.1T
Plt 232 Na 138
CRP <5 K –
urea 7.8
creat 57
pH 7.41

[signature] (SHO)

Referral to RBHSC Hospital Date 8/5/03

Consultant ..... Department Paediatrics

Please arrange: Emergency Admission
Normal / Urgent / Semi Urgent Appointment for O.P Clinic

Details of Patient:

Surname Mitchell Mr. / Mrs. / Miss

Forenames Conor

Previous Surname

Address [redacted]

Date of Birth 12 10 87

Occupation

Phone No.

Postcode:

Hospital Number:

Date of Last Attendance at this Hospital .....

Date of Last Attendance at any other Hospital .....

Name of Hospital:

Reason for Referral unwell 10 days

History / Examination: not feeding, ↓ fluid intake, ↑ drowsiness, poor colour

Provisional Diagnosis: had URTI at start of illness, had short course of penicillin (2-3 days). Chest clear, H.R. 62/min reg.

Past History: well perfused, abdo tender, no guarding, family refuse admission to local hospital

Present Medication: Cerebral palsy. ? Cause of deterioration

Known Allergies:

Other Relevant Information:

DOCTOR'S OR PRACTICE STAMP

Dr. Doyle [redacted]

Doctors Signature ..... (Cypher No.) S410

CM - CAH 088-004-039

CRAIGAVON AREA HOSPITAL ACCIDENT AND EMERGENCY DEPT.

AIGAVON, CO. ARMAGH, BT63 5QQ, N.IRELAND. TELEPHONE NO. [redacted]

Date\Time of arrival 09-MAY-2003 10:51 A/E No. 03/019409

e / ress	[redacted]	DoB 12-OCT-1987 / Age 15 / Sex M / Occ CHILD / Tel [redacted]	GP Name M.D. WILSON / Address [redacted]
tcode			

ciator REF. PARENT/GUARDIAN Arrival PRIVATE TRANSPORT Incident NON-TRAUMA CASE

. Med/Trauma 10⁵⁵ Acuity 2 L C Revised Acuity All Episodes 3 This Year Episodes 1

ory — Previous Illness/Trauma — Allergies — Medication

— Hx c.p.

Unwell 1/7 ... Vomiting

No diarrhoea.

Listless today.

No Rash ... ≈ 22 kg.

P Arthral + muscle spasm

ination P 72 T36.6 RR20. BP 118/69 GCS — Urinalysis — O₂ Sat 97% — T-RTS: ...

Pale

↓ Responsive ...

Dry mucosa

HS I 2 ... — Dehydration

No Resp / meningism

Abdo soft. Non tender. BS.

U-BS PH 7.4

stigation FBP / U&E / Cx / BS. — K 3.06, Glucose 7.7

CRP Blood culture — DR. Sig: [signature] Time: ...

Diagnosis — Dehydration / Vomiting

IT.T. Course Yr	Humotet [ ]
IT.T. Booster Yr	T.T. Course [ ]
IDR.	T.T. Booster [ ]
IGiven By:	Nurse

tment/Management

IV ... Hartmann's 220 mls Bolus

IRef/Disch [ ]	A/E Physio [ ]
IA/E Dress [ ]	A/E Min. Surg. [ ]
IA/E Fract [ ]	CTMA [ ]
IA/E Rev [ ]	D.N. Wait [ ]
IA/E OBS [ ]	Died [ ]
ICAH Admit [ ]	School H.C. [ ]
ITransfer [ ]	Health Vis [ ]
IO.P.D. CAH [ ]	C.A.M.O. [ ]
IO.P.D. Other [ ]	Other [ ]

DEC TO ADM/XFER _____ Dr _____ TIME ADM/XFER _____ Nurse _____

	IDose	IRoute	IOrdered By	IGiven By
Paracetamol	330mg	PO	[signature]	✓ given at 1150 ...
Admit Paeds				Relatives ...

ce at IVerbal: ... | ✓ [signature]

arge IWritten: | Primary Nurse Sig: | Time: | Coded Y/N

IDoctor(s) Coded Y/N | ISig. Time: 11-10 | ISig. [signature] Time:

— Suggested ... Breast Spasm

M Campbell. 12 10

CM - CAH

Accident and Emergency Department Craigavon Area Hospital Group Trust Tel [redacted]

SURNAME	Mitchell	FORENAME	Conor	A+E NUMBER		PROBLEM	
SEX		AGE	12 oct '87	D.OB			
ADDRESS		MARITAL STATUS		TYPE OF INCIDENT		GP ADDRESS	
		MODE ARRIVAL		ACCOMPANIED BY			
		OCCUPATION		TELEPHONE			
		DATE		TIME			

Triage 2 NURSE Lcarragher TIME 1055

PRESENTING COMPLAINT

unwell child

SPECIAL NEEDS

TETANUS STATUS

ALLERGIES NKDA

URINALYSIS

BM

PAIN SCORE

TEMP 36.8 PULSE 77 BP 118/69 RR 20 PFR SAO2 97 1/RA GCS CAP REFIL

ASSESSMENT/HISTORY H/o Cerebral Palsy on epilim
unwell for past 10 days ↓ oral intake.
↑ Drowiness. 0 Rash.
pale ++.
Started on A/B Δ UTI

NURSING INTERVENTION

Obs ☑
Uribag ☑
BM ☑ 7.9 mmols

EVALUATION/OUTCOME

OBS ON DISCHARGE/TRANSFER

TEMP PULSE B/P RR O_2SAT

MEDICATION GIVEN

NAME	ROUTE	DOSE	TIME

RELATIVES PRESENT?

YES ☐ NO ☐

AWARE ☐

CONTACTED? YES ☐

BY WHOM: ____________

TIME BED BOOKED ☐

TIME TRANSPORT BOOKED ☐

LPC 03/01/044

SIGNATURE ON DISCHARGE/ADMISSION:

C.A. 22

HOSPITAL

OBSERVATION CHART

Date	Time	Temp.	Pulse / Resp.	Blood Pressure	TREATMENT
8/5/03	1055	36.8	77, 20	118/69	SPo2 = 94% RA

Trimprint, Armagh

STICK IMMEDIATELY INTO CASE NOTES WHEN PERIOD OF OBSERVATION COMPLETED

NSV Code WMM040N

Surname	First Names	Unit No.	Age	Ward	Consultant
Mitchell	Conor				

T940

NON CURRENT MEDICAL RECORDS (ie OUT OF USE FOR 5 YEARS OR MORE) FOR THIS PATIENT ARE CURRENTLY HELD IN COMMERCIAL STORAGE.

SHOULD THE RETRIEVAL OF THESE RECORDS BE VITAL FOR THE PATIENT'S CURRENT TREATMENT PLEASE INFORM THE MEDICAL RECORDS MANAGER OF THE REASON AND THE RECORDS WILL BE MADE AVAILABLE WITHIN 5 WORKING DAYS.

CONTROL OF THE RETRIEVAL OF CASENOTES FROM COMMERCIAL STORAGE IS REQUIRED DUE TO THE LIMITATIONS OF STORAGE SPACE WITHIN THE TRUST.

E Mackle

.....

MR E MACKLE FRCS
LEAD CLINICIAN FOR OUTPATIENTS

M. H. Neill

.....

MRS H NEILL
OUTPATIENT SERVICES MANAGER

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward/Dept. Address Consultant

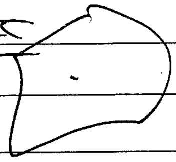
CONNOR MITCHELL

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	8/5/03	1PM
Age	15 YR OLD O.D.	
URINE Protein Sugar Acetone		USUALLY WELL.
		HAS C.P.
WEIGHT kg.		DOESN'T SPEAK USES A
		COMMUNICATION BOARD
		(BRAIN)
		AND - ADVANCED NEURO
→		THERAPY.
Age		x3 SEIZURES SINCE
URINE Protein Sugar Acetone		CHRISTMAS - PETIT MAL
		USUALLY WHEN TIRED
WEIGHT kg.		(STARES THEN SIGHS)
	⇒	VOMITED ABOUT 10/7 AGO
		THEN DEVELOPED SORE
		EARS + THROAT
→		WED PM - TEMP ↑
Age		?RIGOR GP → STARTED
URINE Protein Sugar Acetone		ON PENICILLIN
		THURS PM → VOMITING
WEIGHT kg.		+ CHANGED TO AMOXYCILLIN
		VOMITED AGAIN
	⇒	SEDIMENT IN URINE
		NOTICED 2/7.
		+ DIRTY URINE TODAY

GH 8081

	Date	Clinical Notes
→	O/E	DRY.
Age		CVS PULSE 96
URINE Protein		BP 118/68
Sugar		I+II+0
Acetone		
WEIGHT		
kg.		RS — CLEAR
		GIT  SOFT, NON TENDER
→		BS +/+
Age		• LKKS
URINE Protein		
Sugar		
Acetone		IMP DEHYDRATION
WEIGHT		UTI
kg.		+/- VIRAL ILLNESS
		URINE — PROT.
→		BLOOD
Age		KETONES
URINE Protein		
Sugar		→ CONT IV FLUIDS PHASE
Acetone		DOWNWARDS RE RATE
WEIGHT		→ CONT ANTIBIOTICS
kg.		
		D/W MOTHER → EXPLAINED
→		DIAGNOSIS + TREATMENT
Age		PLAN
URINE Protein		[signature]
Sugar		
Acetone		
WEIGHT		
kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix or Enter in Block Letters: Full Name, Date of Birth, Unit No., Ward/Dept, Address, Consultant

CAHB63929 12/10/1987
MST CONOR MITCHELL
[redacted]

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	8/5/03	ATSP
Age	6:30pm	CONCERN RE RASH ON
URINE Protein		ABDOMEN
Sugar / Acetone		CVS PULSE 66
WEIGHT		I+II+O
kg.		BP 110/56
		DRY
		NO RASH NO PETECHIAE [?]
→		RS - CLEAR
Age		
URINE Protein		GIT - SOFT, NON TENDER
Sugar / Acetone		BS - + (N) OGR [?]
WEIGHT		
kg.		EARS - DRUMS (N)
		MOUTH/THROAT → PT NOT
→		CO-OPERATING
Age		
URINE Protein		FAMILY FEEL PT IS DETERIORATING [?]
Sugar / Acetone		REQUESTING TRANSFER TO
WEIGHT		RVH
kg.		CONTACTED DR [?]
		RE CASE → EXPLAINED [?]
		FINDINGS + CONCERNS
		HAPPY c̄ CURRENT

MANAGEMENT, DOES NOT FEEL HE NEEDS TO RV PT

PT5065

	Date	Clinical Notes
→		⇒ CONTACTED PAED REGISTRAR,
Age		HAS VERY KINDLY AGREED
URINE Protein		TO ASSESS PT
Sugar		
Acetone		
WEIGHT		⇒ NAUSEA → CYCLIZINE 25mg
kg.		IV GIVEN
		CXR - NAD

Rapidpoint400

ARTERIAL SAMPLE
08.05.2003 21:25
System Name A-E
System ID 0401-03677

ACID/BASE 37.0 °C

pH	7.622↑	
pCO_2	2.21↓	kPa
pO_2	83.73↑	kPa
HCO_3^-act	16.7	mmol/L
HCO_3^-std	22.7	mmol/L
BE(B)	-2.2	mmol/L
BE(ecf)	-4.5	mmol/L
$ctCO_2$	17.2	mmol/L

OXYGEN STATUS 37.0 °C

Hct	0.35↓	
ctHb(est)	11.9	g/dL
O_2SAT(est)	100.0	%

ELECTROLYTES

Na^+	134.4	mmol/L
K^+	3.40↓	mmol/L
Ca^{++}	0.93↓	mmol/L
Ca^{++}(7.4)	1.02	mmol/L
Cl^-	103	mmol/L
AnGap	18.1	mmol/L

METABOLITES

Glu	5.2	mmol/L

PATIENT RANGES

pH	7.350 - 7.450
pCO_2	4.50 - 6.50
pO_2	10.00 - 15.00
Na^+	133.0 - 146.0
K^+	3.50 - 4.50
Ca^{++}	1.05 - 1.30
Cl^-	96 - 106
Glu	3.6 - 5.5
Hct	0.37 - 0.54

↓,↑=Out of range

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward/Dept. Address Consultant	CONOR MITCHELL 12/OCT/87.

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	8/5/03	
Age	8:45 pm	PAED REG ASSESSING PT
URINE Protein		SHE STATES PT HAD
Sugar		ATONIC SEIZURE WHICH
Acetone		
WEIGHT		RESOLVED WITHIN SECONDS
kg.		A SECOND SEIZURE
		FOLLOWED AGAIN LASTING
		SECONDS AFTER WHICH NO
→		RESP. EFFORT BEING
Age		MADE
URINE Protein		BAG + MASK IMMEDIATELY
Sugar		
Acetone		APPLIED SATS 89%
WEIGHT		CARDIAC MONITOR.
kg.		CONSULTANT PAEDIATRICIAN
		PRESENT
		ANAESTHETICS CALLED
→		PUPILS DILATED +
Age		UNRESPONSIVE TO
URINE Protein		LIGHT
Sugar		
Acetone	CVS	PULSE 130 (GOOD OUTPUT)
WEIGHT		BP 112/78
kg.		[illegible]
		→ IV PHENYTOIN LOADING
		DOSE GIVEN AS PER
		BNF DOSAGE

→ RPT ABG

PT5065

CM - CAH

	Date	Clinical Notes
→		IV ACYCLOVIR ADDED
Age		THOUGH UNLIKELY TO BE
URINE Protein		ENCEPHALITIS
Sugar		D/W RADIOLOGY CONTACTED
Acetone		URGENT CT REQUIRED
WEIGHT		NO SIGNS OF INTRACRANIAL
kg.		DISCUSSED MANAGEMENT
		TO DATE C/W SMITH
		HAPPY THAT APPROPRIATE
Age		ABXS HAD BEEN GIVEN
URINE Protein		FEELS APPROPRIATE
Sugar		MANAGEMENT HAS
Acetone		BEEN GIVEN TO DATE
WEIGHT		? INTRACEREBRAL
kg.		BLEED AETIOLOGY OF
		ACUTE DETERIORATION
→		
Age		DR DGM CONSULTANT ON
URINE Protein		CALL CONTACTED AGAIN
Sugar		- WILL COME IN
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters Full Name Date of Birth Unit No. Ward/Dept. Address Consultant

CONNOR MITCHELL
12/OCT/1987

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	8/5/2003	
Age		CT BRAIN
URINE Protein		
Sugar		
Acetone		– Provisional Report Only
WEIGHT		
kg.		– No old scans to compare.
		– Very abnormal scan.
→		
Age		– Large left sided porencephalic cyst with smaller right porencephalic cyst.
URINE Protein		
Sugar		
Acetone		
WEIGHT		– Most of the supratentorial area is of CSF density and there is only minimal cortical tissue
kg.		
		– There is abnormal high density material on the tentorium cerebelli and around the basal cisterns suggesting subarachnoid haemorrhage.
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		– The basal cisterns appear tight.
kg.		
		– Comparison with old scans would be of benefit

Paul Rice
RADIOLOGIST

PT5065

	Date	Clinical Notes
→	May 8 2003	Called to see ~ 2100 hr
Age	2300	15y/o ♂ with CP/Sz disorder
URINE Protein		10 day febrile illness with vomiting
Sugar		and poor intake. Given IVF, Ciprofloxacin
Acetone		Sudden onset of tonic contraction associated
WEIGHT		with pallor and apnoea followed by
kg.		hypotonia
		Required bag + mask ventilation
→		Treated with IV Phenytoin → no response.
Age		Pupils became fixed and dilated
URINE Protein		No response to ventilation despite normal
Sugar		oxygenation, HR.
Acetone		Intubated by anaesthesia
WEIGHT		CT scan → Subarachnoid bleed in abnormal
kg.		brain (large porencephalic cyst)
→		Discussed ē mother, grandmother and grandfather
Age		with Dr. McEneaney
URINE Protein		Transfer to ICU
Sugar		
Acetone		
WEIGHT		MSuntto
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

CONOR MITCHELL
12/10/87

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	08/05/03	Intubation
Age	2300	ICU contacted at 2100 - Informed Dr
URINE Protein		15 yr ♂ c cerebral palsy, epilepsy in MAU.
Sugar		Attended MAU immediately c anaes. nurse.
Acetone		
WEIGHT		On arrival pt unresponsive GCS 3/15. ↓Resp.
kg.		Pupils fixed & dilated. No seizure activity
		Effective bag mask ventilation c guedel
		in situ by Dr A. Murdock (Med Reg)
→		Sats 98% on 15Lmin. Pulse 100bpm
Age		BP 84/40.
URINE Protein		– 2nd cannula inserted 18G (L) forearm
Sugar		– Intubated (RSI) c Size 6.5 ETT, Cricoid.
Acetone		
WEIGHT		Sux. 25mg (pt 22kg). Grade I laryngoscopy
kg.		Tube 18cm at lips. A/E Equal through
		out. Upper airway secretions ++
		– pt put on ventilator
→		– NG Tube (12G) passed - stomach
Age		aspirated
URINE Protein		– Transferred to CT Scanner for Brain
Sugar		CT Scan.
Acetone		
WEIGHT		Unevent fu transfer to scanner &
kg.		then to ICU. No haemodynamic
		instability.
		Obs on arrival in ICU Pulse 80bpm SR
		BP 84/48, GCS 3 (No sedation)

GH 8081

	Date	Clinical Notes
→		Handed over to Dr Naphade & Dr Mc Caughey. A Gluteuson (SHO)
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

MITCHELL

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age	8/5/3	2300
URINE Protein		
Sugar		
Acetone		History + exam as noted previously
WEIGHT		
kg.		10 day history of febrile illness.
		sudden deterioration tonight.
→		Pupils fixed, dilated.
Age		CT scan pending as noted.
URINE Protein		Damned with DNSH as
Sugar		below.
Acetone		Extensive discussion with
WEIGHT		parents + grandparents re.
kg.		diagnosis + prognosis.
→		
Age		D M Cleary
URINE Protein		
Sugar		
Acetone	8/8/03	CONTACTED NEUROSx →
WEIGHT		DISCUSSED CASE C MR
kg.		COOKE, HE WILL RIV
		SCAN + CONTACT MYSELF
		RE FURTHER MANAGEMENT
		IN PAEDIATRICS

PT5065

	Date	Clinical Notes
→	00^{30}	Message for Mr Cooke – Neurosurgery –
Age		has seen CT Scan; no indication for
URINE Protein Sugar Acetone		surgical intervention at present.
WEIGHT kg.		Relatives keen to consider hyperbaric therapy –
		I have explained that this is not appropriate for
		current condition.
→		[signature]
Age		
URINE Protein Sugar Acetone	9/5/3	– 10.05 AM.
	McCALLISTER	DAY 1 ICU.
WEIGHT kg.	HUTCHINSON.	
	ORBINSON.	Pupils Dilated. No reaction to light
	BRADY	No independent breathing.
		No muscle relaxant / No sedatives
→		No blink response.
Age		Not catheterised due to difficulty [illegible] trauma [illegible]
URINE Protein Sugar Acetone	o/e	BP 84/65 GCS = 3/15
		PA = 145/SINUS
WEIGHT kg.	pH = 7.45	SATS = 99.
	PO_2 = 12.7	RESP = 21 / NO SPONTANEOUS.
	PCO_2 = 4.08	
	Bicarb – 23.1	SIMV (SIEMENS) – [illegible] 15 – SPONT = 0.
→	BE = -2.5	FiO_2 = 30%
Age	O_2 Sats = 98.2%	
URINE Protein Sugar Acetone	Na = 149.	No creps. No wheeze. AE = AB. Peripherally well perfused. Sinus Rhythm
	K = 3.8	
WEIGHT kg.	Urea = 5.9	HS I+II [illegible]
	Creat – 65	
	Ca = 2.58	PLAN: Brainstem responses to be tested
	Alb = 37	To O/W Family –
	Cl = 18.7.	[signature] #403 SHO

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
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Unit No.
Ward/Dept.
Address
Consultant

CAHB63929 12/10/1987
AGR
MST CONOR MITCHELL
[redacted]

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→	9/5/03	All appearances are that this unfortunate young fellow is brain stem dead. – no corneal reflexes no cough + no breathing. → to discuss family.
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→	9/5/03 11.00	→ reflexes to supraorbital stimulation
Age	9.5.03	Discussed by telephone w/ Dr Phillip Jones,
URINE Protein	11.00	Hyperbaric Unit, University of Dundee.
Sugar		
Acetone		
WEIGHT		Whereas Conor has had hyperbaric therapy in past, agreed
kg.	01382 632084	that this is currently inappropriate, as good oxygenation is being achieved, & ventilation is not possible in hyperbaric unit.
→		Suggests partial demyelination as possible Δ for acute deterioration.
Age		
URINE Protein		
Sugar		
Acetone	9/5/3	Brady
WEIGHT	@1500	
kg.	(1)	↓ Dose of PANTOPRAZOLE to 20mg IV
	(2)	Note Na = 7150 → 50mls/hr Sterile water
		No output recordings due to difficult Catheterisation last night → Catheter removed

GH 8081

EMMA MCDONALD

	Date	Clinical Notes
→	9 - 5 - 3	BABY.
Age	15[illegible]5	(UROLOGY)
URINE Protein		SPOKE TO DR QUACKIN RE: CATHETERISATION
Sugar		OF PATIENT - HAPPY FOR US TO PROCEED
Acetone		BUT IF ANY RESISTANCE → UROLOGY REQ
WEIGHT		
kg.		
		BABY
		(RVH ICU)
→	15[20]	SPOKE TO DR DUNLOP, REGISTRAR PAED. ICU.
Age		TOOK DETAILS AND SPOKE TO CONS. P. ICU
URINE Protein		WOULD REQUEST A PAEDIATRICIAN TO R/V
Sugar		PATIENT AS TO APPROPRIATENESS OF
Acetone		PAED ICU. WOULD LIKE TO SPEAK TO
WEIGHT		AAEDS CAN DIRECT POST-R/V
kg.		
	15[25]	BABY
		(CAH PAEDS).
→		SPOKE TO DR MCDONALD PAED. STAFF GRADE
Age		WILL ATTEND PATIENT THIS PM TO R/V
URINE Protein		RE: ABOVE DR DUNLOP REQUIREMENTS.
Sugar		
Acetone		
WEIGHT	15[40].	DR MCDONALD (PAEDS STAFF GRADE)
kg.	PMH.	Resp. arrest after admitted ? viral illness
	large	Possible small subarachnoid.
	porencephalic	Ventilated
→	cyst.	GCS has improved from 3 → 6
	Not attending any	Responding to voice (move toes)
Age	clinics	
URINE Protein		GE. Slim
Sugar		Body habitus of 8-9 yr old child
Acetone		quadriplegia
WEIGHT		
kg.		
		ICU staff feel he would be more appropriately
		managed in PAEDS ICU - agree he has
		body habitus of younger child. DIW PAEDS ICU

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
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Consultant

Consol [illegible]

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		consultant + explained this.
Age		[signature]
URINE Protein	9.5.3	Brady
Sugar / Acetone	16⁰⁰ →	(Tony CHISAKUTA · CONS RVH (ICU)).
WEIGHT		D/W ABOVE CONS. RE: T/F.
kg.		HAS FORMALLY ACCEPTED PATIENT FOR
		T/F
		WILL NEED TO D/W FAMILY.
→		
Age		→ SPOKE c DR MCCALLISTER RE: T/F to
URINE Protein Sugar Acetone		RVH PAEDS. He will D/W Developments
		[signature]
WEIGHT		
kg.	9/5/3	Brady
		Aseptic technique — 4mls instillagel used.
	16¹⁵	Size 8ch Simplic (Silastic Catheter)
→		inserted. 5mls in Balloon
Age		Prior to insertion = Excoriation on
URINE Protein Sugar		internal surface of foreskin noted.
Acetone		No blood from meatus, CLEAR urine
WEIGHT		exuding from meatus → Proceeded c insertion
kg.		free urine drainage ++.
		Residual = 80mls urine + free flowing
		@ 2mins post insertion.
		→ Hourly [illegible] [signature]

GN 8081

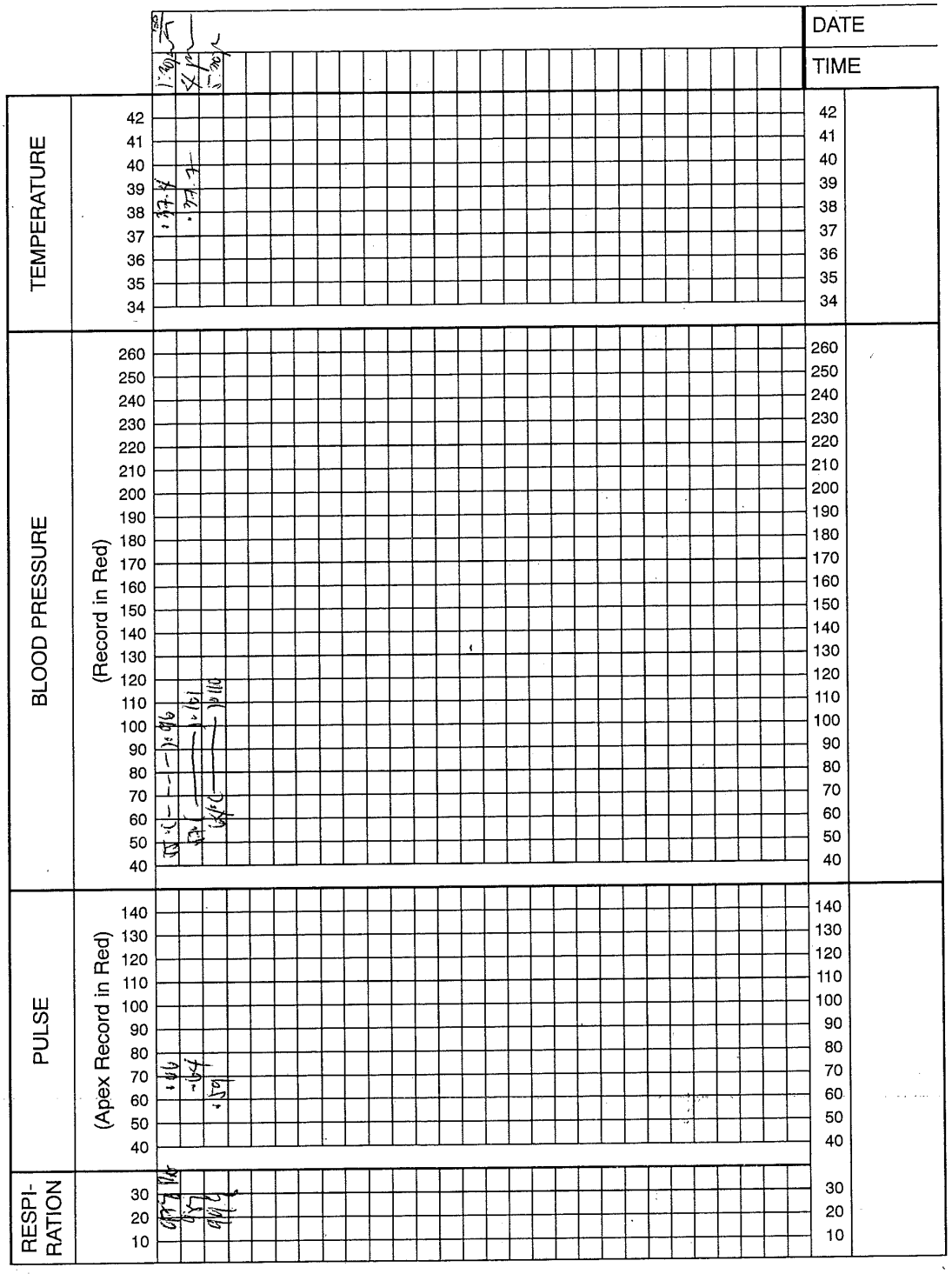
	Date	Clinical Notes
→		In view of weight + complex
Age	9/8/05	problems → Transfer to RBHSC
URINE Protein Sugar Acetone	[signature]	Sick children.
WEIGHT kg.	A/W	Needs ambulance + 100 nurse
		for transfer
		[signature]
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

Affix Label
or enter in
Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

CONOR MITCHELL

DATE

TIME



URINE:	COLOUR	GLUCOSE	KETONE	PROTEIN	BLOOD	OTHER
DATE:						

AREA HOSPITAL GROUP TRUST
Caring Through Commitment

ALLERGIES: ? Penicillin – vomiting

DIET:

UNIT No.: B179929 AGE: 15

NAME: Conor Mitchell

ADDRESS:

CONSULTANT: Dr Murphy WARD: MAU

PLEASE READ PRESCRIBING NOTES OVERLEAF

PLEASE PRINT CLEARLY

DATE COMMENCED		NON-INJECTABLE DRUGS GENERIC NAME	DOSE	ROUTE	TIMES OF ADMINISTRATION STANDARD 8 am	12 md	4 pm	10 pm	OTHERS		ORDERED BY	CANCELLED BY AND DATE	PHARMACIST
8/5/03	1	EPILIM	200mg	O	✓		✓	✓			CR		
8/5/03	2	VOLTAROL	50mg	PR	✓		✓	✓			CR	CR 8/5	
8/5/03	3	PARA CETAMOL	1g	PR	✓	✓	✓				CR		
8/5/03	4	VOLTAROL	50mg	PR	8 hrly		pm				CR		
~~8/5/03~~	5	~~EPILIM~~	~~200mg~~	~~PO~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~CR 8/5~~	
	6												
	7												
	8												
	9												
	10												
	11												
	12												
	13												
	14												
	15												
	16												
	17												
	18												
	19												
	20												

PLEASE PRINT CLEARLY

DATE COMMENCED		INJECTABLE DRUGS GENERIC NAME	DOSE	ROUTE	TIMES OF ADMINISTRATION STANDARD 8 am	12 md	4 pm	10 pm	OTHERS		ORDERED BY	CANCELLED BY AND DATE	PHARMACIST
8/5/03	21	CIPROXIN	200mg	IVI	✓			✓			CR		
	22												
	23												
	24												
	25												
	26												
	27												
	28												

DATE	ONCE-ONLY DRUGS GENERIC NAME	DOSE	ROUTE	TIME	ORDERED BY	GIVEN BY	DATE	ONCE-ONLY DRUGS GENERIC NAME	DOSE	ROUTE	TIME	ORDERED BY	GIVEN BY
8/5/03	CIPROXIN	200mg	IVI	1pm	CR	[illegible]							
8/5/03	VOLTAROL	50mg	PR	1pm	CR	[illegible]							
5/8/03	CEFUROXIME	250mg	IV	7:30pm		[illegible]							

WWW 974

	REGULAR PRESCRIPTION RECORDING SHEET						COMMENTS ON DISCREPANCIES
DATE	8 AM	12 MD	4 PM	10 PM	OTHER TIMES	OTHER TIMES	
8/6/07	Init	Init	Init	Init	3rd 5p Init 6	Init	
	Init	Init	Init	Init	Init	Init	
	Init	Init	Init	Init	Init	Init	
	Init	Init	Init	Init	Init	Init	
	Init	Init	Init	Init	Init	Init	
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	Init	Init	Init	Init	Init	Init	
	Init	Init	Init	Init	Init	Init	
	Init	Init	Init	Init	Init	Init	

NOTES FOR PRESCRIBERS

Prescribe GENERICALLY (except for proprietary combinations and sustained release formulations)

CLEARLY PRINT the FULL drug name.

Doses of 1 gram or more should be written in GRAMS (approved abbreviation is 'g').
Doses of less than 1 gram should be written in MILLIGRAMS (approved abbreviation is 'mg').
Doses of less than 1 milligram should be written in MICROGRAMS (there is NO abbreviation for micrograms).
Doses of less than 1 microgram should be written in NANOGRAMS (there is NO abbreviation for nanograms).

'ITS should NOT be abbreviated to 'U'

All generic drugs which are supplied in the hospital, are manufactured under DHSS license and have been tested for purity, bioavailability and dissolution characteristics.

There is no evidence for the widely promoted view that licensed generic drugs are inferior to the proprietary brand.

Nurses should not be expected to translate from trade names to generic names or vice versa.

Nurses are understandably anxious that they should not be made responsible for shortcomings in the writing of prescriptions and ARE ENTITLED TO REFUSE TO ADMINISTER DRUGS which are improperly prescribed.

INTAKE / OUTPUT CHART

CRAIGAVON AREA HOSPITAL GROUP (HSS) TRUST

Affix Label: Conor Mitchell.

24 hours beginning 9 a.m.	Date: 8 MAY 2003

VOLUMES IN MLS. ONLY

TIME	INTAKE				OUTPUT			REMARKS
	Oral Type	Intravenous			Urine	Faeces	Vomit / Tube	and Other Routes
		Volume Erected	Type	Volume In				
9 a.m.								
10 a.m.								
11 ~~a.m.~~ 20		110 mls	Hartmanns	110				
~~noon~~ 1145		110 mls	Hartmanns	110				
12 noon p.m.		110 ml Hartmanns 20 and Cannula		110				
2 p.m.		Venflon extravasated						
3 p.m.		Dr Totten informed of spasms						
4 p.m. 10		FLUIDS RECONNECTED.						
5 p.m.				250				
6 p.m.								
7 p.m. 40		250 ml normal saline started to run						
8 p.m.			for 60					
9 p.m.								
10 p.m.								
11 p.m.								
12 m.n.								
1 a.m.								
2 a.m.								
3 a.m.								
4 a.m.								
5 a.m.								
6 a.m.								
7 a.m.								
8 a.m.								

24-HOUR PERIOD ENDING AT 9.00 a.m. ON DATE BELOW

INTAKE			
	By mouth	I'venous or other routes	Total
Total for 24 hours	ml	ml	ml
TOTAL INTAKE			ml

OUTPUT		
Urine	Faeces	Vomit/Tube
ml	ml	ml
TOTAL OUTPUT		ml

Date:	Surname:	First Names:	Unit No.:

BLOOD TRANSFUSION CHECK WITH SISTER/STAFF/NURSE/DOCTOR

1. PATIENT'S NAME
2. UNIT NUMBER
3. BLOOD GROUP
4. LAB. REF. NUMBER

THEN: CHECK TEMPERATURE, PULSE, B.P. at 15 min. intervals after putting up blood – REPORT IMMEDIATELY ANY CHANGE

N.B. Patients receiving intravenous therapy only for periods of longer than 48 hours require potassium replacement as well as sodium replacement if there is any sizeable loss of intestinal contents even if oliguric. They may be oliguric because of potassium deficiency. If in doubt ask for expert advice.

N.B. It is dangerous to correct "acidosis" on the basis of the "base deficit" on the Astrup estimation without knowledge of the plasma Na value. It is permissible for the expert to do this in emergency situations such as cardiac arrest.

10 ml / kg. 22 kg.

PARTICULARS OF INTRAVENOUS FLUIDS TO BE TAKEN

Bottle	Amount	Type of Fluid	To be added to bottle	Time to be commenced	Time completed	Prescribers Signature	Nurses Signatures
	220 mls	Hartmann	—	1/2 hr.			110 mls at 1120 110 mls at 1145
1	1L	N. Saline	20 mmol KCl	8hrs		CC	
	1L	5% dextrose	20 mmol KCl.	8hrs		CC	
	1L	N. Saline		8hrs		CC	
4-10 PM	250 mls	N. Saline		4hr		CC	
	250 ml	N. saline		6hr	6hr	CC	
	250 ml	N. saline		8hr		CC	

CRAIGAVON
AREA HOSPITAL
GROUP TRUST
Caring Through Commitment

PATIENT'S PROPERTY

I have been advised to restrict to a minimum the amount of property including cash brought into Hospital and to hand to the Ward Sister/Nurse/Midwife in Charge, as soon as possible any articles I wish to be kept in safe custody for which a receipt will be given.

I understand that I am responsible for all personal property brought into Hospital.

I hereby indemnify the Craigavon Area Hospital Group Trust and its nominated officers against any liability in respect of loss or damage to, personal property of any kind, in whatever way the loss or damage may occur.

Signed: Joanna Mitchell
Patient / Relative

Witness: A Bell
Nurse / Midwife

Ward: MAU

Patient's Hospital No.: B63929

Date: 8/5/07

WWW 988

NPCB 1

CRAIGAVON AREA HOSPITAL

ASSESSMENT SHEET

GENERAL WARDS
CARE OF ELDERLY

SURNAME MITCHELL
FORENAMES CONOR
ADDRESS [redacted]

PREFERS TO BE ADDRESSED AS CONOR
MARITAL STATUS MA
DATE AND TIME OF ADMISSION 8/5/03 1.30 pm
HOSPITAL NUMBER 1963929 WARD MAU
OCCUPATION N/A ICU 8.5.03 2300hrs.
DATE OF BIRTH 12/10/87 AGE 15

NEXT OF KIN NAME JOANNA MITCHELL / Judy grandmother
RELATIONSHIP MOTHER
ADDRESS S/A

TELEPHONE NO. DAY
NIGHT [redacted]

SIGNIFICANT OTHERS

RELIGION [redacted]
SPIRITUALLY ATTENDED

VALUABLES
DENTURES NONE TOP BOTTOM
SPECTACLES } NONE OTHER
HEARING AID }

BOOKLET GIVEN TO PATIENT / NAMED RELATIVE

REASON FOR ADMISSION

vomiting ↓ oral intake Dehydration
Respiratory Arrest ? post seizure UTI ?

PATIENTS PERCEPTION OF CURRENT HEALTH STATUS

has cerebral palsy

RELATIVES PERCEPTION OF CURRENT HEALTH STATUS

mother present on admission, aware of his status

MEDICAL INFORMATION (Past History)

ALLERGIES NKDA

MEDICATION ON ADMISSION (to include oral contraceptives)

MEDICATIONS BROUGHT INTO HOSPITAL YES / (NO)

COMMUNITY RESOURCES PRIOR TO ADMISSION

TYPE OF ACCOMMODATION BUNGALOW HOUSE WITH FAMILY
NURSING SERVICES } NONE
SOCIAL SERVICES }
OTHER GP - DR. WILSON

COMMUNITY REFERRALS

DATE

OS 10925

WWW 612

CRAIGAVON AREA HOSPITAL

ASSESSMENT OF ACTIVITIES OF LIVING

AL Usual routines:
what he / she can and cannot do independently

1.	Maintaining a safe environment: DROWSY, HAD SPASMS	7.	Controlling body temperature: T- 37.4°C ON ADMISSION
2.	Communicating: HAS CEREBRAL PALSY. CAN'T SPEAK BUT COMMUNICATES BY BODY LANGUAGE	8.	Mobilising: CRAWLS ON HIS TUMMY AT HOME
3.	Breathing: NOT IN RESPIRATORY DISTRESS. O_2 SAT - 97% RA	9.	Working and playing: PLAYFUL AT HOME
4.	Eating and drinking: HE HAS POOR APPETITE LAST 10 DAYS	10.	Expressing sexuality: N/A. L.M.P.
5.	Eliminating: BLADDER - C/O UTI. BOWEL - NO PROBLEM	11.	Sleeping: GOOD SLEEPING PATTERN - 11 HRS AT NIGHTTIME
6.	Personal cleansing and dressing: FULL ASSISTANCE TO HIS HYGIENE	12.	Dying: N/A

CONSULTANT DR. MURPHY SIGNATURE OF NURSE [signature] DATE 8/5/03

CRAIGAVON AREA HOSPITAL GROUP TRUST

INTENSIVE CARE UNIT

RELATIVE COMMUNICATION SHEET

PATIENTS NAME Conor Mitchell	1245 Mother, grandmother and brother spoken to by Dr. Mc Allister. S/N mullin, CNS M Lennon, Dr. Hutchinson Dr. Robinson, Dr. also present. Dr. Mc Alliste informed them that Conor had made a slight improvement this morning but at present it was still to early to predict prognosis, in view of pre-existing cerebral palsy. The mother had expressed concern in relation to possible bacterial / viral infections and how these would affect the brain. It was explained to them that he would be more susceptible and probably slower to respond to treatment, but how long would be difficult to predict. The prother commented on comparing previous brain scan to the current scan, but Dr. Mc Alister explained that at present it would not change any current management.
UNIT NUMBER B63929	
NAME OF NEXT OF KIN Joanne Mitchell	
RELATIONSHIP Mother	
WHO WILL VISIT Mum + partner Grandmother.	
COMMUNICATION TO FAMILY AND OTHERS	
family spoken to by Dr McEneany and Dr Smith following CT Scan — explained results of CT Brain showed small haemorrhage in centre of brain. On arriving in ICU - grandmother spoken to by Dr Mc Caughey. asked Dr Mc Caughey about possibility of Conor having hyperbaric O2 therapy She insisted that if she could contact Dr James re hyperbaric oxygen therapy she would like Dr Mc Caughey to speak to him. Dr Mc Caughey did explain that Conor condition was very serious and that he ~~was~~ required ventilation Conor was unable to breath at present without the ventilator He went on to say that at present he felt hyperbaric Oxygen therapy was inappropriate. Family anxious at present requiring constant reassurance & information	It was further explained to them that in relation to relative facilities in ICU, that this would have to be restricted to family members only, and to the designated areas.

P.T.O

S/N Mullin

INTENSIVE CARE UNIT

Then family present did appear anxious, and apprehensive, and stated that they were expecting news that ~~th~~ Conor [redacted] could possibly die and that the machine could be turned of, and were very keen to hear news in relation on to his current clinical state. They ~~appeared~~ to understand the information relayed to them S/N Aflin.	

CRAIGAVON AREA HOSPITAL GROUP TRUST

INTENSIVE CARE UNIT

24 HOUR NURSING CARE PLAN

CAHB63929 12/10/1987
A69
MST CONOR MITCHELL
[redacted]

DATE 9th May 2003.

CRAIGAVON AREA HOSPITAL GROUP TRUST
INTENSIVE CARE UNIT

24 HOUR NURSING CARE PLAN

IDENTIFIED PROBLEMS	PLANNED NURSING CARE EARLY SHIFT	PLANNED NURSING CARE LATE SHIFT OR 12 HOUR SHIFT	PLANNED NURSING CARE NIGHT SHIFT
CARDIOVASCULAR			
PAIN			
ARTERIAL LINE			
COMMUNICATION			
FAMILY ANXIETY			
MECHANICAL VENTILATION			
TRACHEOSTOMY			
OXYGEN THERAPY			
INTRAVENOUS LINES			
NUTRITION			
ELIMINATION 1			
ELIMINATION 2			
PERSONAL HYGIENE			
TEMPERATURE			
MANUAL HANDLING			
MOBILITY			
SLEEP			
SPIRITUAL NEEDS			

SIGNATURE OF PRESCRIBING NURSE:

DATE & TIME:

CRAIGAVON AREA HOSPITAL GROUP TRUST

INTENSIVE CARE UNIT

24 HOUR EVALUATION AND PROGRESS NOTES

TIME		SIGNATUR
0800	Handover received by S/N Mullin. Lines rezeored	
	equipment checked.	
	Pahent ventilated simv Peep 2 cms H_2O PS 5cms	
	FiO_2 0.30. NAD spontaneous effort breathing.	
	BP 88/52 HR 128 SR. Temp 35°, warm touch blanket	
	in place.	
	Adrenaline infusing @ 3mls/hr	
	Nil sedation infusing; GCS 3/15 Pupils size 8 fixed	
	+ dilated, no reaction to light, no obvious movement	
	of limbs.	
	Routine bloods drawn ef.	
	ABG satisfactory Po_2 12.7 Pco_2 4.08 pH 7.45	
	K^+ 3.8 Glucose 4.9.	
	NG sec in place, pahent incontinent of urine	
	pad in place. To be catheterised later.	
1000	SIB Dr mc Allister: for brain stem death tests.	
	Pahent's ~~leg~~ Knee flexed to pain, therefore not	
	brain stem dead, further tests abandoned.	Mullin.
	Dr. to speak with family.	
	Family in attendance throughout the morning	
	when speaking to Conor ie. ask appropriate questions	
1200	he responds by moving his toes, and further	
	by moving his (R) leg bringing knee up towards	
	abdomen. GCS 7/15. Pupils remain dilated + fixed	Mullin.
	Family spoken to by Dr. mc Allister, see	
	communication sheet.	
1330	Handover from S/N Mullin, care taken over	
	by S/N Brooker. Conor fairly stable at	
	present with Adrenaline + Haldyphos infusion	
	running. Ventilated on S.IMV @ 12 breaths	

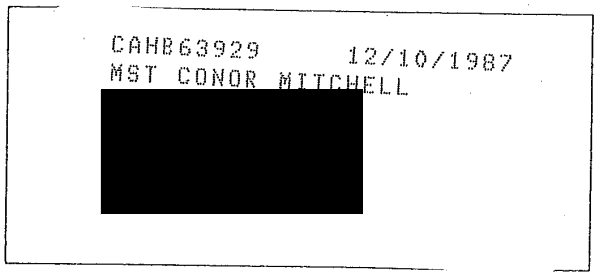
24 HOUR EVALUATION AND PROGRESS SHEET

TIME	
	then reduced down to 8 breaths by Dr McCaughey.
1400	Repositioned, incontinent on pads again. Skin OK ? for urinary catheterisation later. Mouth + eye care, tongue very dry.
1430	NG feed commenced @ 20ml/hr. 165mls aspirated. pH 1. 40mg dose of pantoprazole queried with medical staff, reduced to 20mg dose. ABG good but Na ↑ 154. Sterile H_2O prescribed at 50ml/hr + erected.
1580	SIB CAH Paediatrician to confirm that Conor could be treated as a child in a paediatric icu. PICU in RVH then contacted, who have accepted ~~to~~ Conor. Ambulance contacted + booked provisionally for 5.30 pm. Dr MCAllister to make family aware at 5pm when he returns.
1615	Size 8.0 urinary catheter inserted, 70mls residual urine. Conor moving all limbs throughout procedure.
1700	Dr McAllister spoke to family + explained that Conor had become more responsive this afternoon + we were transferring Conor to PICU in RVH. Family very happy to hear this.

CRAIGAVON AREA HOSPITAL GROUP TRUST

INTENSIVE CARE UNIT

24 HOUR NURSING CARE PLAN



DATE 8/5/03

CRAIGAVON AREA HOSPITAL GROUP TRUST
INTENSIVE CARE UNIT

24 HOUR NURSING CARE PLAN

IDENTIFIED PROBLEMS	PLANNED NURSING CARE EARLY SHIFT	PLANNED NURSING CARE LATE SHIFT OR 12 HOUR SHIFT	PLANNED NURSING CARE NIGHT SHIFT
CARDIOVASCULAR			A B C D F G
PAIN			A D
ARTERIAL LINE			A B C D F
COMMUNICATION			A C D E F
FAMILY ANXIETY			Mechanical Vent A B C D E F G H
MECHANICAL VENTILATION			Family. A C D E F
TRACHEOSTOMY			—
OXYGEN THERAPY			—
INTRAVENOUS LINES			A B C D E F
NUTRITION			A C D E H
ELIMINATION 1			Unsuccessful catheterisation
ELIMINATION 2			A D
PERSONAL HYGIENE			A B D
TEMPERATURE			A Warm touch
MANUAL HANDLING			A B C D E
MOBILITY			A B C D E
SLEEP			No sedation GCS = 3
SPIRITUAL NEEDS			N

SIGNATURE OF PRESCRIBING NURSE: RB

DATE & TIME: 9/5/03 07:50

CRAIGAVON AREA HOSPITAL GROUP TRUST

INTENSIVE CARE UNIT

24 HOUR EVALUATION AND PROGRESS NOTES

TIME | SIGNATURE

0100 New patient admitted from CT scanner to ICU (no medical notes available)
H/O Admitted to medical ward this pm
H/o feeling unwell for one week - vomiting & decreased oral intake. Diagnosed urinary tract infection. Condition deteriorated dramatically at 7pm - breathing deteriorated ? seizure. taken to CT scanner - CT Brain grossly abnormal. Scans sent to Belfast.
On admission to ICU patient glasgow coma scale of 3 pupils fixed & dilated.
BP 88/50 mean 65 HR 75 No CVP.
SIMV mode of ventilation. Assisted rate 12 O2 60%.
peep +5 pressure support 20 no spontaneous effort. ABG PaO2 55.6 PaCO2 1.95 O2 ↓ 30%.
creamy secretions off chest. Brachial atrial line inserted U+E FBC checked.
W subclavian CVC inserted by Dr McCaughey.
K+ 2.5 KCL infusion commenced at 5mls/hr
BP 80/50 adrenaline single strength infusing at 2 mls/hr. HR ↑ following adrenaline.
Grandmother spoken to by Dr McCaughey - see communication notes.
? position of CVC line - see ABG from CVC
Adrenaline infusing through line as per Dr McCaughey
KCL stopped.
K+ ↓ 1.9 Dr Naphade contacted - New CVC (R) femoral inserted - meanwhile KCL (120mmols) to Hartmanns (1000mls infusing at 40mls/hr
Difficulty inserting line - x-ray KCL now infusing via central line
problem with blood sugar ↑13.0 actrapid infusion at 5mls/hr blood sugar at 3.0mmols/L actrapid off. Slowing ↑
Temp 34 or below. warm touch insitu
Skin intact
Addiphos infusion in progress phosphate < 0.3

24 HOUR EVALUATION AND PROGRESS SHEET

TIME	
	Relatives seeking constant attention from D.'s + nursing staff anxious ++ reassurance given
07.00	BP 90/50 mean 71 HR 125 CVP +8 SIMV mode ventilation peep +2 pressure support 5 O_2 30% assisted rate ↑ 12 P_{CO_2} 5.12 P_{O_2} 12.5 Creamy secretions via suctioning Temp 33.2

24

CRAIGAVON AREA HOSPITAL GROUP TRUST
INTENSIVE CARE UNIT

RISK ASSESSMENT – MANUAL HANDLING OF PATIENTS

PATIENT'S NAME: UNIT NUMBER:

PATIENT DETAILS – DIAGNOSIS/DISABILITIES	AIDS INTRODUCED TO REDUCE HANDLING ACTIVITY
? Subarachnoid haemorrhage Cerebral palsy WEIGHT: underweight STATURE: Small	Slide sheets
ABILITY TO ASSIST None **HANDLING CONSTRAINTS** ET tube Central line arterial line naso-gastric tube	**POTENTIAL HIGH RISK PROBLEMS** none
ENVIRONMENTAL pumps ventilator drip stands Warm touch.	**MANUAL HANDLING INVOLVED/FREQUENCY** 2-4 hourly 2 nurses.

This form should be completed within 24 hours of admission.
Any changes in patient handling over 24 hours should be written in flow chart.

CRAIGAVON AREA HOSPITAL GROUP TRUST
INTENSIVE CARE UNIT

DATE & TIME	PHYSICAL/MENTAL CONDITION OR SEDATION	ABILITY TO ASSIST SELF/AIDS USED	HANDLING ACTIVITY/FREQUENCY/AIDS USED. PRESSURE RELIEVING AIDS	POTENTIAL RISK	SIGNATURE
9/5	no sedation glasgow coma Scale 3	none	2-4hrly Evolution bed	not at present	R.B

PRESSURE SORE PREVENTION PATHWAY

CAHB63929 12/10/1987
MST CONOR MITCHELL
[redacted]

Patient Name: Conor Mitchell

Ward: ICU

Consultant: Dr Murphy

Unit Number : _____

Date: 8/5/03

Remember

You are responsible for acting on your findings - instigate and document preventative care as appropriate.

Re-evaluate the patient's risk status each time their condition changes. If their risk status does not change record the fact weekly in acute care and monthly in long term care.

Be extremely vigilant for (further) breakdown if your patient has a history of:

- **Discoloured or broken pressure areas;**
- **Poor tissue perfusion, e.g. respiratory / cardiac disease, on inotrope support, diabetes, peripheral vascular disease;**
- **Poor tissue perfusion, e.g. Gastro-intestinal disease, alcohol abuse, malnutrition;**
- **Immobility, e.g. Multiple Sclerosis, paraplegia, lying for longer than 2 hours on a hard surface (floor, x-ray table, ambulance stretcher, casualty trolley, theatre table).**

The Braden Scale is an aid to clinical judgement, it cannot replace it.

Braden Scale - For Predicting Pressure Sore Risk

RISK FACTOR	SCORE/DESCRIPTION			
Sensory Perception Ability to respond meaningfully to pressure related discomfort.	**1. Completely Limited** Unresponsive (does not moan, flinch or grasp) to painful stimuli; due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body surface.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over $^1/_2$ of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort
Moisture Degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Often Moist** Skin is often, but not always moist. Linen must be changed at least once a shift.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry, linen only requires changing at routine intervals.
Activity Degree of physical activity	**1. Bedfast** Confined to bed	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	**4. Walks Frequently** Walks outside the room at least twice a day and inside the room at least once every 2 hours during waking hours.
Mobility Ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.
Nutrition Usual food intake pattern [1]NPO: Nothing by mouth [2]IV: Intravenously [3]TPN: Total parental nutrition	**1. Very Poor** Never eats a complete meal. Rarely eats more than $^1/_3$ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Take fluids poorly. Does not take a liquid dietary supplement **OR** is NPO[1] and/or IV[2] for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only $^1/_2$ of any foods offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meats, dairy products) each day. Occasionally will refuse a meal, but will be usually take a supplement if offered. **OR** is on tube feeding or TPN[3] regime which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
Friction and Shear	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** - Moves freely or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** - Moves in bed and on chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	

CAHB63929 12/10/1987
MST CONOR MITCHELL
[redacted]

Patient Name: Conor Mitchell

Ward/Unit : ICU

Braden Score : **Low risk 19-23**
At Risk 18 or less

Risk Sore on Admission: 6 Date: 9/5

SECTION A - Risk Assessment (Refer to Braden Scale)

Date:	9/5/03							
Time:	04.00							
Sensory Perception	1							
Moisture	1							
Activity	1							
Mobility	1							
Nutrition	1							
Friction & Shear	1							
Total Score	6							
Signature	RG							

SECTION B - Patient's admitted with pressure sores from: Home; Residential/ Private Nursing Home; Other Hospital

Pressure sore(s) present on admission? Yes/No If NO, Signature _____ Date _____

If YES please give details:

Private Sector	[ ] Name of Home		GP	
Other Hospital	[ ] Hospital Name		Ward	
Own Home	[ ] GP			

ADMITTED

Pressure Sore ID Number	Site	Grade	Dressing(s) (Pre-admission)	Type of Mattress (Pre-admisson)	Date Photograph(s) Taken (Grade 2 and above)	Consent for photograph (please tick)
1A						
2A						
3A						
4A						

Signature: Date:

SECTION C - Pressure Sore(s) developed since admission to Craigavon Area Hospital Group Trust

DEVELOPED

Pressure Sore ID Number	Place first identified (Ward/Unit)	Date first identified	Site	Grade	Date Photograph Taken (Grade 2 and above)	Consent for photograph (please tick)	Signature
1D							
2D							
3D							
4D							

please affix addressograph here

Patient Name: ____________________________

Ward/Unit : ____________________________

Braden Score : **Low risk 19-23**
At Risk 18 or less

Risk Sore on Admission:________Date: ______

SECTION A - Risk Assessment (Refer to Braden Scale)

Date:								
Time:								
Sensory Perception								
Moisture								
Activity								
Mobility								
Nutrition								
Friction & Shear								
Total Score								
Signature								

Date:								
Time:								
Sensory Perception								
Moisture								
Activity								
Mobility								
Nutrition								
Friction & Shear								
Total Score								
Signature								

Date:								
Time:								
Sensory Perception								
Moisture								
Activity								
Mobility								
Nutrition								
Friction & Shear								
Total Score								
Signature								

PRESSURE SORE PREVENTION PATHWAY

Name: Conor Mitchell **Unit number:** B63929 **Ward:** ICU

SECTION D

To be completed if patient is "at risk" or becomes "at risk" (Braden 18 or less)	PRESSURE SORE PREVENTION PATHWAY	Date & Signature
EDUCATIONAL NEEDS Advise patient of their 'AT-RISK' status and the actions that they can take to prevent pressure damage.	Verbal advice on pressure relief given YES/(NO) Copy of DoH booklet given to patient/carer YES/NO If NO state reason, e.g patient unconscious, unable to understand Unconscious	RB
REPOSITIONING NEEDS If patient cannot reposition themselves instigate a repositioning schedule.	Patient is able to reposition self YES/(NO) Advised to reposition self every 15 minutes when up to sit YES/NO If NO: Repositioning Schedule instigated (YES)/NO If NO: State reason _____	RB
MOVING AND HANDLING NEEDS Contact the Back Care Co-Ordinator if you are unsure about moving and handling needs.	Patient moves independently YES/(NO) If NO: Sliding Sheet required YES/NO Hoist required YES/NO Other _____ (Refer to Manual Handling Risk Assessment)	RB
THERAPY BEDDING NEEDS Use Therapy Bed Flowchart to choose appropriate support surface. NB If Yes to this section instigate pressure relief whilst waiting for the system to arrive. Eg Position change, use of 30° tilt etc. (if condition allows).Record on notes	Pressure reducing foam mattress is now standard on all beds. Dynamic System ordered YES/(NO) Type of system ordered _____ Date system supplied _____ Frequency of need for mattress review Daily Bed cradle required YES/(NO)	RB
THERAPY CUSHION NEEDS All wheelchair users must be referred to an Occupational Therapist for a seating assessment.	Pressure reducing cushion required YES/(NO) Type of cushion supplied _____ Date cushion supplied _____ OT referral required YES/(NO) If YES, date referred _____	RB
NUTRITIONAL NEEDS If any box is ticked, refer to Dietician within 24 hours: Special dietary requirement [ ] Body Mass Index less than 20 [ ] Body Mass Index greater than 30 [ ] Weight loss of 3.5kg in last 3 months [ ] Regularly refused meals, missed meals over a period of 3 weeks [ ] Braden Nutritional Score 1 or 2 [ ] Grade 3 or 4 pressure sore present [ ]	Patient has special nutritional needs YES/(NO) If YES: patient referred to dietician YES/NO Date referred: _____ Comments:	RB
SKIN CARE NEEDS If patient has frequent episodes of incontinence • use a mild cleansing agent or a washcream • consider barrier cream If patient has dry skin use a moisturiser	Patient has special skin care needs YES/(NO) If YES: pH 5.5 soap / wash required YES/NO Barrier cream required YES/NO Emollient required YES/NO Other _____	RB

RECORD OF CHANGES TO PATHWAY

Name: _____ **Unit number:** _____ **Ward:** _____

This section should be completed if interventions have changed e.g. change of therapy bed, change in repositioning schedule.

	Date	Record Changes to Pathway	Signature
EDUCATIONAL NEEDS			
REPOSITIONING NEEDS			
MOVING AND HANDLING NEEDS			
THERAPY BEDDING NEEDS			
THERAPY CUSHION NEEDS			
NUTRITIONAL NEEDS			
SKIN CARE NEEDS			
REFERRALS			

REPOSITIONING CHART

CAHB63929 12/10/1987
MST CONOR MITCHELL
[redacted]

ıttress type: Evolution bed

ɔosition 2-4 hrly (State frequency) when in bed

shion type: _____

ɹeposition _____ (State frequency) when up to sit

Action to relieve pressure damage may include 30 degree tilt, turns, standing or mobilising patient. Report any changes in skin condition to registered nurse.

24 hour clock	Action	Signature	24 hour clock	Action	Signature
0.800			20.00		
0.900			21.00		
10.00			22.00		
11.00			23.00	Repositioned	RR
12.00			24.00	Repositioned in the bed	RR
13.00			01.00		
14.00			02.00		
15.00			03.00	Repositioned	RR
16.00			04.00		
17.00			05.00	Repositioned	RR
18.00			06.00		
19.00			07.00		

Inspect and document the condition of all pressure areas <u>at least</u> twice daily, e.g. when washing the patient in the am and when settling the patient at night.

Pressure Point	Occipital	Sacrum	Buttock	Hips	Knees	Heels	Other (State)	Other (State)
AM Shift Time: _____ Sig: _____			(R) (L)	(R) (L)	(R) (L)	(R) (L)		
PM Shift Time: _____ Sig: _____			(R) (L)	(R) (L)	(R) (L)	(R) (L)		
Night Shift Time: 02:00 Sig: RR	A	A	(R) A (L) A	(R) A (L) A	(R) bruised (L) bruised	(R) A (L) A	bruising to knees from crawling on floor	

Code for table:

A - Intact
B - Blanching erythema
1 - Non blanching erythems, Grade 1 sore
2 - Grade 2 Pressure Sore
3 - Grade 3 Pressure Sore
4 - Grade 4 Pressure Sore
E - Eschar
D - Discoloured
U - Unable to checksore

REPOSITIONING CHART

Patient Name: Conor Mitchell.
Unit Number: _____
Ward: ICU.
Date: 9.5.03

Mattress type: Clinisert
Reposition 3 hrly (State frequency) when in bed
Cushion type: N/A
Reposition _____ (State frequency) when up to sit

Action to relieve pressure damage may include 30 degree tilt, turns, standing or mobilising patient. Report any changes in skin condition to registered nurse.

24 hour clock	Action	Signature	24 hour clock	Action	Signature
0.800			20.00		
0.900	Heels + elbows repositioned.		21.00		
10.00		sfullin	22.00		
11.00	Rolled onto side + back		23.00		
12.00		sfull	24.00		
13.00			01.00		
14.00	Rolled + pressure areas checked.	PS.	02.00		
15.00			03.00		
16.00	Rolled + skin checked	PS.	04.00		
17.00			05.00		
18.00			06.00		
19.00			07.00		

Inspect and document the condition of all pressure areas <u>at least</u> twice daily, e.g. when washing the patient in the am and when settling the patient at night.

Pressure Point	Occipital	Sacrum	Buttock	Hips	Knees	Heels	Other (State)	Other (State)
AM Shift Time: 1200. Sig: sfullin	A	A	(R) A (L) A	(R) A (L) A	(R) A (L) A	(R) A (L) A		
PM Shift Time: 1700 Sig: PS.	A	A	(R) A (L) A	(R) A (L) A	(R) A (L) A	(R) A (L) A		
Night Shift Time: _____ Sig: _____			(R) (L)	(R) (L)	(R) (L)	(R) (L)		

Code for table:

A - Intact
B - Blanching erythema
1 - Non blanching erythems, Grade 1 sore
2 - Grade 2 Pressure Sore
3 - Grade 3 Pressure Sore
4 - Grade 4 Pressure Sore
E - Eschar
D - Discoloured
U - Unable to checksore

NSW Code WWOE176C

CRAIGAVON AREA HOSPITAL GROUP TRUST
INTENSIVE CARE UNIT

INVASIVE LINES AND EQUIPMENT

PATIENT: Conor Mitchell.

DATE INSERTED	TYPE AND SITE OF INVASIVE LINE OR EQUIPMENT e.g. CVC, ART LINE, TRACHE	DATE REMOVED	SENT FOR O&S YES/ NO	SIGNATURE
8/5/03	(L) brachial arterial line			
	(L) Subclavian CVC			
7/5/03	(R) femoral CVC			
9/5/03	Reintubated with size 6.5 cr tube			

80/CA66/2

HEAD INJURY CHART

GUIDELINES TO MANAGEMENT

Affix Label or enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

THE LEVEL OF CONSCIOUSNESS IS THE MOST IMPORTANT SINGLE SIGN IN CASES OF HEAD INJURY. IT MUST BE OBSERVED IN ALL CASES.

KEEP THE AIRWAY CLEAR —— THIS IS THE MOST IMPORTANT SINGLE ITEM IN MANAGEMENT.

POSITION The patient should be nursed on alternate sides, turning every two hours with the nose and mouth clear of the bed.

RESTLESSNESS If the patient is very restless, padded side walls should be used, and the knees and ankles padded. Remember that restlessness is frequently due to a distende bladder. Protect the patient from injuring himself but do not hold him down by force.

SKIN Turning two hourly and padding pressure points should be started from admission. Keep the skin dry.

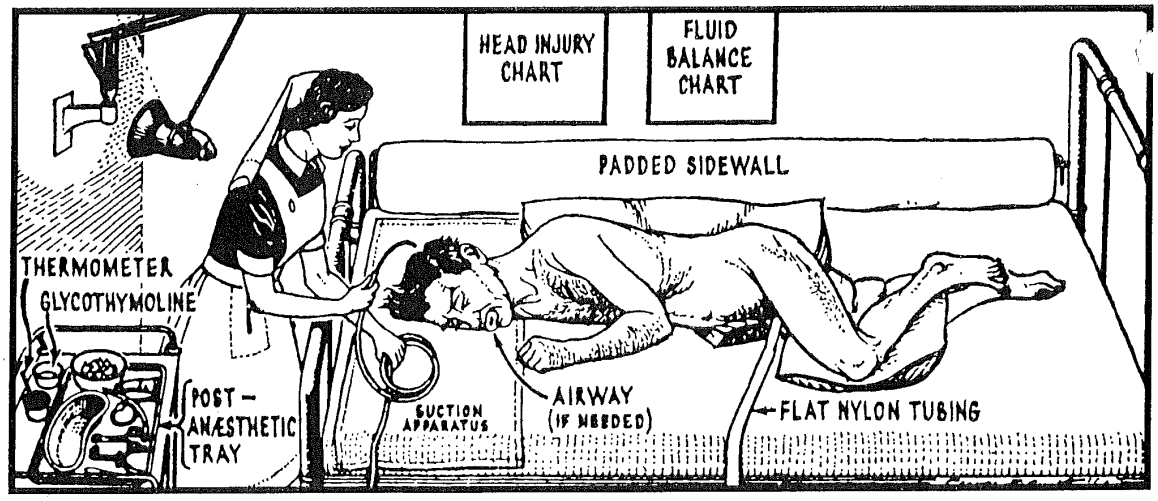
MOUTH Swab the mouth from admission; do not irrigate.

EYE Protect the cornea by keeping the lids covered with saline soaked swabs.

FEEDING If unconsciousness is prolonged for more than 24 hours intravenous or tube feeding may be required. A fluid balance chart must be started. (Oesophageal tube No. 16 in the stomach).

URINE A self retaining catheter should be inserted. In the male, Paul's tubing may be used in some cases.

WOUNDS Keep the wounds protected with a minimum of dressing and firm bandages. BE ON THE LOOK OUT FOR OTHER INJURIES:



Signs of increasing intracranial pressure:

The pulse rate usually falls
The blood pressure usually rises
The temperature usually rises
The respiratory rhythm usually alters
A fall in the level of consciouness

} ANY RAPID ALTERATIONS OF THESE SHOULD BE REPORTED

Trimprint, Armagh NSV Code WMM045N

HB63929 12/10/1987
T CONOR MITCHELL
[redacted]

HEAD INJURY CHART

2003.
8th may 9th may

				DATE
				TIME

Times: 2300, 2400, 0100, 0200, 0300, 0400, 0500, 0600, 0800, 0900, 1000, 1100, 1200, 1300, 1400, 1500, 1600, 1700

COMA SCALE

			Score	
Eyes open			4	Eyes closed by swelling = C
			3	
		To pain	2	
		None	1	
Best verbal response		Orientated	5	Endotracheal tube or Tracheo-stomy = T
		Confused	4	
		Inappropriate	3	
		Incomprehensible	2	
		None	1	
Best motor response		Obey commands	5	Usually record the best arm response
		Localise pain	4	
		Flexion to pain	3	
		Extensive to pain	2	
		None	1	

GCS 3 3 4 3 7 6 6 7 7 7

Pupil scale (mm)		Blood pressure	Temp °C
●	1	230	40
●	2	220	39
●	3	210	38
●	4	200	37
●	5	190	36
●	6	180	35
●	7	170	34
●	8	160	33
●	9	150	32
●	10	140	31
		130	30
		120	
		110	
		100	
		90	
		80	
		70	
		60	
		50	
		40	
		30	
		20	
		10	

Pupil size (mm)

Pupils				
Right	Size	7 7 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8		+ Reacts - No Reaction c. Eye closed
	Reaction	- - - - - - - - - - - - - - - - - -		
Left	Size	7 7 7 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8		
	Reaction	- - - - - - - - - - - - - - - - - -		

LIMB MOVEMENT

			Record right (R) and left (L) separately where there is a difference between the two sides.
ARMS	Normal Power		
	Weak		
	Abnormal response	feet twitches	
	No response		
LEGS	Normal Power		
	Weak		
	Abnormal response	(L) (R)	

NPCB 4

C[illegible]IGAVON AREA HOSPITAL GROUP (HSS) [illegible]UST

NURSING REPORT / EVALUATION

Date	Problem	Nursing Report / Evaluation (Include Non Regular Prescription)	Signature
8/5/03	1:30pm	admitted this 15 year old child referred by his GP due to vomiting and	
		↓ oral intake. He was unwell for 10 days, not feeding, has ↓ fluid intake	
		and ↑ drowsiness, had poor color, had URTI at start of illness, was	
		given penicillin (2-3 days). FBP, U&E, CRP, blood cultures taken at A/E	
		IV access on, was given 220 ml of Hartmann's solution.	
		clinical observation taken on admission to MAU T 37.4 P 66 B/P 96/55, O2 sat-97% RA	
		spasms noted several times, seen by SHO	
		IV fluid of normal saline 200 ml started for 4°, IV ciproxin 200 mg given	
		and voltarol 50 mg PR given	
		urinalysis ☑ + protein, + blood and large ketones, MSSU ☑	
		for CXR / AXR ☐, venflon extravasated - Dr. Totten informed at 2 pm	[illegible]
		and at 2-30PM and 2-45PM. Family concerned about patient	
		not receiving IV fluids. DR Nicholson contacted. Venflon resited	
		by DR Totten @ 4PM - IV fluids reconnected @ 4.10pm.	F J Lavery
		Still awaiting specimen of urine ☒ (Rpt sample	[illegible] Dickey
		requested by lab).	
	5:40	patient noted to have spasms, clinical observation taken T-37.7, P 69	
		B/P 114/64 sat = 99% O2 delivered 24%	[illegible]

SURNAME	CHRISTIAN NAMES	UNIT NO.	WARD
'CONOR	MITCHELL		MAU

NSV Code WWW[illegible]

CM - CAH

088-004-091

NPCB 4

CRAIGAVON AREA HOSPITAL GROUP (HSS) TRUST

NURSING REPORT / EVALUATION

Date	Problem	Nursing Report / Evaluation (Include Non Regular Prescription)	Signature
		small rashes noted on abdomen and thighs, seen by SHO, paracetamol ½g PR given	MBullen
		O2 changed to nasal cannula	MBullen
		3pm mother anxious to speak to Doctor re Connor spasm	
8/5/03		and intermittent rash	
Day		3.55pm seen by Reg Dr Murdoch reassured that Connor is	
		suffering from a Urinary Tract infection and Dehydration	
		above being treated with IV antibiotics for UTI and Intravenous	
		fluids for Dehydration	
		Has examd NAD	
		appears to have ? bite tongue with a sharp tooth, small amount dark fluid at side of mouth	
		family not happy with reassurance from Dr Murdoch (Reg)	
		feels he is deteriorating and would like him to	
		be transfered to Royal Victoria Belfast - Dr Murdoch going	
		to speak to Consultant who is Dr McEneaney	
		6.30pm Dr Murdoch spoke to Dr McEneaney no change	
		in medication Paediatric Reg will assess. IV	
		~~Urgent~~ Portable chest X-Ray have requested 7.15pm CO Bullen	
		7.10pm family called thought Connor had ? stopped breathing	

SURNAME CHRISTIAN NAMES UNIT NO. WARD

Trimprint, Armagh

088-004-092

CM - CAH

NPCB 4

C. GAVON AREA HOSPITAL GROUP (HSS) . ST

NURSING REPORT / EVALUATION

Date	Problem	Nursing Report / Evaluation (Include Non Regular Prescription)	Signature
8/5/07		? had a seizure.	
		ECG	
	7[22]p	See & Dr Murdoch Reg breathy satisfactory obs stable	
		Rotable Chest x Ray at 7[30]p	
		7[40]p IV Cyclizine 25ys given & Dr Murdoch Reg	Wilson
		Chest x Ray - normal	
		ECG poor quality trace no obvious abnormality.	
		& Await Paediatric Reg	Wilson
		8[20]p. Seizure	
	21[00]	Condition deteriorating. Breathing very poor.	
		Patient's breathing supported & Ambubag.	
		Airway inserted & suctioning given	
		DR Murdoch requested anaesthetist on call.	
	21[05].	SIB Anaesthetist on call.	
	21[15]	Patient intubated - Bubbly - Suctioning given -	
	21[10]	IV Phenytoin 300mgs injected via syringe	
		drives to veins over 20mins.	
	21[25]	NG tube passed - 50mls coffee grounds	

SURNAME: MITCHELL

CHRISTIAN NAMES: Connor

UNIT NO.: B63929

WARD: 44

NSV Code WWWE

088-004-093

CM - CAH

NPCB 4

CRAIGAVON AREA HOSPITAL GROUP (HSS) TRUST

NURSING REPORT / EVALUATION

Date	Problem	Nursing Report / Evaluation (Include Non Regular Prescription)	Signature
		Suctioned	
	2137.	Patient ~~placed~~ put on ventilator.	
		BP 82/55 P99 SPO2 99%	
	2145.	Patient transfered to CT Scanner for	
		emergency CT Brain.	
	2230	Transfered to Intensive Care Unit.	[illegible]
	2240.	Dr McEneaney and Dr Shephard spoke	
		family and explained results of CT Brain	
		which ~~showed~~ showed small haemorrhage	
		in centre of brain.	[illegible]

SURNAME CHRISTIAN NAMES UNIT NO. WARD

Trimprint, Armagh

088-004-094

CM - CAH

CRAIGAVON AREA HOSPITAL GROUP TRUST

Medical Wards

NURSING PRESCRIPTION FOR CARE

DATE	A/L	PROBLEM	GOAL	INTERVENTION	EVALUATION	SIG.
1/1/09	4	Error	a. Patient will maintain an	Observe that intravenous fluids and naso-gastric	on going	
		nutritional/fluid intake is less	adequate fluid balance.	feeds are given as prescribed at the correct time,		
		than his/her body	b. Patient will maintain	volume and rate.		
		requirements due to:	his/her usual weight.	Observe administration set for kinks or air bubbles.		
				Ensure administration set is taped securely in place.		
				Record accurate fluid balance chart.		
				Measure and record patient's weight daily/alternate		
				days/weekly etc.		
				Refer patient to Dietitian.		

PATIENTS NAME: CONOR MURCHER

HOSPITAL NUMBER:

NCP/10

CRAIGAVON AREA HOSPITAL GROUP TRUST

NURSING PRESCRIPTION FOR CARE

Medical Ward

Date Problem Identified	A/L No.	POTENTIAL PROBLEM	GOAL (desired outcome)	NURSING INTERVENTION	Nursing Signature for Care		
					Prescription Date	Review Date	Discont. Date
8/5/09	1	Patient has pain	Pain will be reduced to a level acceptable	Assess pain, patients report about	8/5/09	on going	
			to the patient.	severity, position, etc. Observe for			
			There will be absence of identified pain	rigidity, rise or fall in pulse or BP, pallor or			
		due to ill pers	behaviour.	other signs of pain.			
				Position patient and regulate environment			
				eg. (temp., noise, light) for maximum			
				comfort.			
				Give analgesia as prescribed.			
				Make positive statements about its'			
				effectiveness in minimising pain.			
				If inadequate pain relief, request alteration			
				of prescription.			

PATIENTS NAME: COLM MCCANN

HOSPITAL NUMBER:

Trimprint, Armagh NSV Code WOE124N

CRAIGAVON AREA HOSPITAL

Continuation

INVESTIGATIONS

DATE	INVESTIGATIONS	SIGNATURE	DATE	INVESTIGATIONS	SIGNATURE	DATE	INVESTIGATIONS	SIGNATURE
8/5/17	Amfbord	[illegible]						
	FBC, U&E, CRP,	[illegible]						
	Blood cultures							
	CXR ☐, AXR ☐	[illegible]						
8/5/03	Portable Chest x-ray							
8/5/03	Cap Keton + Protein ~~MSSU~~ Urinalysis ☑							
8/5/03	~~[illegible]~~ MSSU ☑	[illegible]						

An initial assessment of each patients' mobility/handling requirements must be made during their admission procedure and reviewed whenever changes occur.

INDIVIDUAL PATIENT HANDLING RISK ASSESSMENT FORM

Affix addressograph label:

Approximate Body Build			
Obese		Tall	
Above average		Med	
Average		Short	✓
Below average	✓		

CRAIGAVON AREA HOSPITAL GROUP TRUST
Caring Through Commitment

Patients name: CONOR MITCHELL Ward/Department: MAU

Name, Title and Signature of Assessor: [signature] Date and Time of Initial Assessment: 8/5/03 1:30 PM

Patients Diagnosis

What are the Manual Handling Problems?

Problems with comprehension, behaviour, co-operation HAS CEREBRAL PALSY

e.g. ability to understand and respond to direct instructions ( ), hearing ( ), sight problems ( ), unpredictable behaviour ( ), medication ( ), other ( )

If yes, please comment .....

Does the patient have a history of falls? Yes [ ] No [✓]

If yes, please comment .....

Clinical Constraints

i.e. IV Therapy ( ), tubing ( ), chest drains ( ), Dynpnoea ( ), fatigue ( ), unable to weight bear ( ), skin condition/wound ( ), effects of pain ( ), limit of disfunction ( ).

Others - please specify HAS SEIZURES AT TIMES

Comments:.....

Environmental Constraints

i.e. cot sides ( ), monitors ( ), furniture ( ), access/space for use of equipment ( ), trailing leads ( ).

Others - please specify NONE

Comments .....

Equipment/aids normally used by patient (see key overleaf for examples):

NONE

088-004-098

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NB Manual Lifting of Patients should be avoided except in emergency situations.
Patient Handling Equipment/Aids should be used at <u>ALL</u> times.
Staff must ensure that patient has been given instructions in the use of equipment, where appropriate.

Key for lifting equipment, aids or transfer techniques or other: (only select what is readily available in your ward/department)

1. Supervised
2. Assistance x 1) This does <u>NOT</u>
3. Assistance x 2) imply "lifting"
4. Hoist – sling lifter
5. Hoist – stand aid
6. Hoist – bath seat
7. Hoist – other, please specify
8. Phil-e-slide
9. Rotating disc
10. Easy slide
11. Log roll
12. Rope ladder
13. Monkey pole
14. Walking frame
15. Walking stick
16. Wheelchair
17. Sani-chair
18. Other, please specify eg Transfer Belt or Banana Board

Date	8/5/09				
Assessor Signature	[illegible]				
Transfer up the bed	3				
Transfer from bed to chair/commode	3				
To toilet on commode chair	3				
To bath/shower on sani-chair	3				
Bed bathed by nurse/auxiliary	3				
Repositioning/turning in bed	3				
Assistance sit to stand	3				
Assistance with personal hygiene	3				
Assistance with walking	3				
Assistance with feeding	2				
Transfer from bed-trolley-bed	3				
Others					
Comments					

MULTIDISCIPLINARY TEAM - PREPARATION FOR DISCHARGE FROM

Name: CONOR MITCHEL

RELEVANT INFORMATION:

Dietitian: **Date:**	**Occupational Therapist:** **Date & Reason:**	**Social Worker:** **Date:**
Speech Therapist: **Date & Reason:**	**Physiotherapist:** **Date & Reason:**	**Geriatric Assessment Referral:** **Date:** **District Nurse Referral:** **Date:**

088-004-100

CM - CAH

Patient's Name

Unit No

Date			**Date**		
	Patient informed of discharge Time	Yes/No/NA		Discharge address, if other than	Yes/No
	Next of kin informed	Yes/No/NA		Discharge letter received	Yes/No
	Occuptional Therapy	Yes/No/NA		Medication/Supplies received	Yes/No
	Physiotherapy	Yes/No/NA		Discharge guidelines/advice Received	Yes/No
	Diabetic Nurse Specialist	Yes/No/NA		Patient/Relatives notified of Review date	Yes/No
	Dietitian	Yes/No/NA		Transfer sheet completed	Yes/No/NA
	Speech Therapy	Yes/No/NA		Arrangement of transport	Yes/No
	District Liaison Nurse	Yes/No/NA		Venflon removed	Yes/NA
	Social Services	Yes/No/NA			
	Valuables and property returned	Yes/No/NA			
	Geriatric referral	Yes/No/NA			
	Psychiatric referral	Yes/No/NA			
				Signature of Nurse: Date:	

CRAIGAVON AREA HOSPITAL

BRADEN SCALE - For Preventing Pressure Sore Risk

HIGH RISK: Total Score < 12 MODERATE RISK: Total Score 13 - 14
LOW RISK: Total Score 15 - 16 if under 75 years old OR 15 - 18 if over 75 years old.

DATE OF ASSESS.→ 08/05/07

RISK FACTOR	SCORE/DESCRIPTION				1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure related discomfort	1. COMPLETELY LIMITED Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of sedation OR limited ability to feel pain over most of body surface.	2. VERY LIMITED Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sencory impairment which limits the ability to feel pain or discomfort over ½ of body.	3. SLIGHTLY LIMITED Responds to verbal commands, but cannot always communicate discomfort or need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. NO IMPAIRMENT Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	2			
MOISTURE Degree to which skin is exposed to moisture.	1. CONSTANTLY MOIST: Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	2. VERY MOIST: Skin is often, but not always moist. Linen must be changed at least once a shift.	3. OCCASIONALLY MOIST: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. RARELY MOIST: Skin is usually dry, linen only requires changing at routine intervals.	3			
ACTIVITY Degree of physical activity.	1. BEDFAST: Confined to bed.	2. CHAIRFAST: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheel chair.	3. WALKS OCCASIONALLY: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. WALKS FREQUENTLY: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.	2			
MOBILITY Ability to change and control body position.	1. COMPLETLEY IMMOBILE: Does not make even slight changes in body or extremity position without assistance.	2. VERY LIMITED Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. SLIGHTLY LIMITED Makes frequent though slight changes in body or extremity position independently.	4. NO LIMITATIONS Makes major and frequent changes in position without assistance.	2			
NUTRITION Usual food intake pattern [1] NPO: Nothing by mouth [2] IV: Intravenously [3] TPN: Total parenteral nutrition	1. VERY POOR Never eats a complete meal. Rarely eats more than ⅓ of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO[1] and/or maintained on clear liquids or IV[2] for more than 5 days.	2. PROBABLY INADEQUATE: Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. ADEQUATE: Eats over half of most meals. Eats a total of 4 servings of protein (meats, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered OR is on a tube feeding or TPN[3] regimen which probably meets most of nutritional needs.	4. EXCELLENT Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	1			
FRICTION AND SHEAR	1. PROBLEM Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity contractures or agitation leads to almost constant friction.	2. POTENTIAL PROBLEM Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. NO APPARENT PROBLEM Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.		2			
TOTAL SCORE	**Total score of 12 or less represents HIGH RISK**				12			

ASSESS	DATE	EVALUATOR SIGNATURE/TITLE	ASSESS	DATE	EVALUATOR SIGNATURE/TITLE
1	08/05/07		3	/ /	
2	/ /		4	/ /	

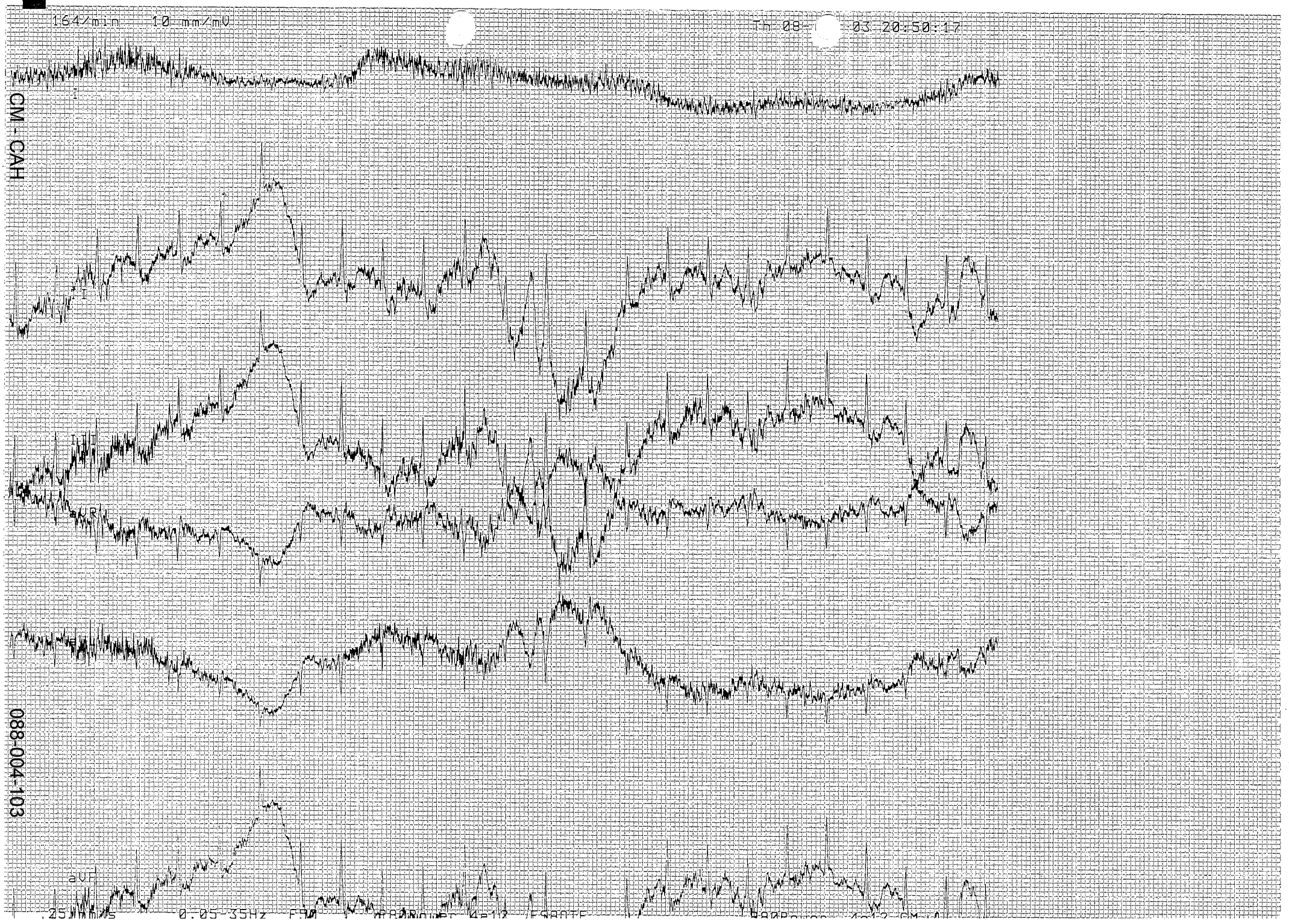
PATIENTS NAME CONOR MITCHELL WARD/ADDRESS MAU

DATE OF BIRTH 12/10/87

HOSPITAL NUMBER CM - CAH H63929 CONSULTANT/GP DR.

088-004-102

Trimprint, Armagh NSV Code WOD156N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Th 08-
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CM - CAH
I
II
III
aVR
aVL
aVF
V1
V2
V3
V4
V5
V6
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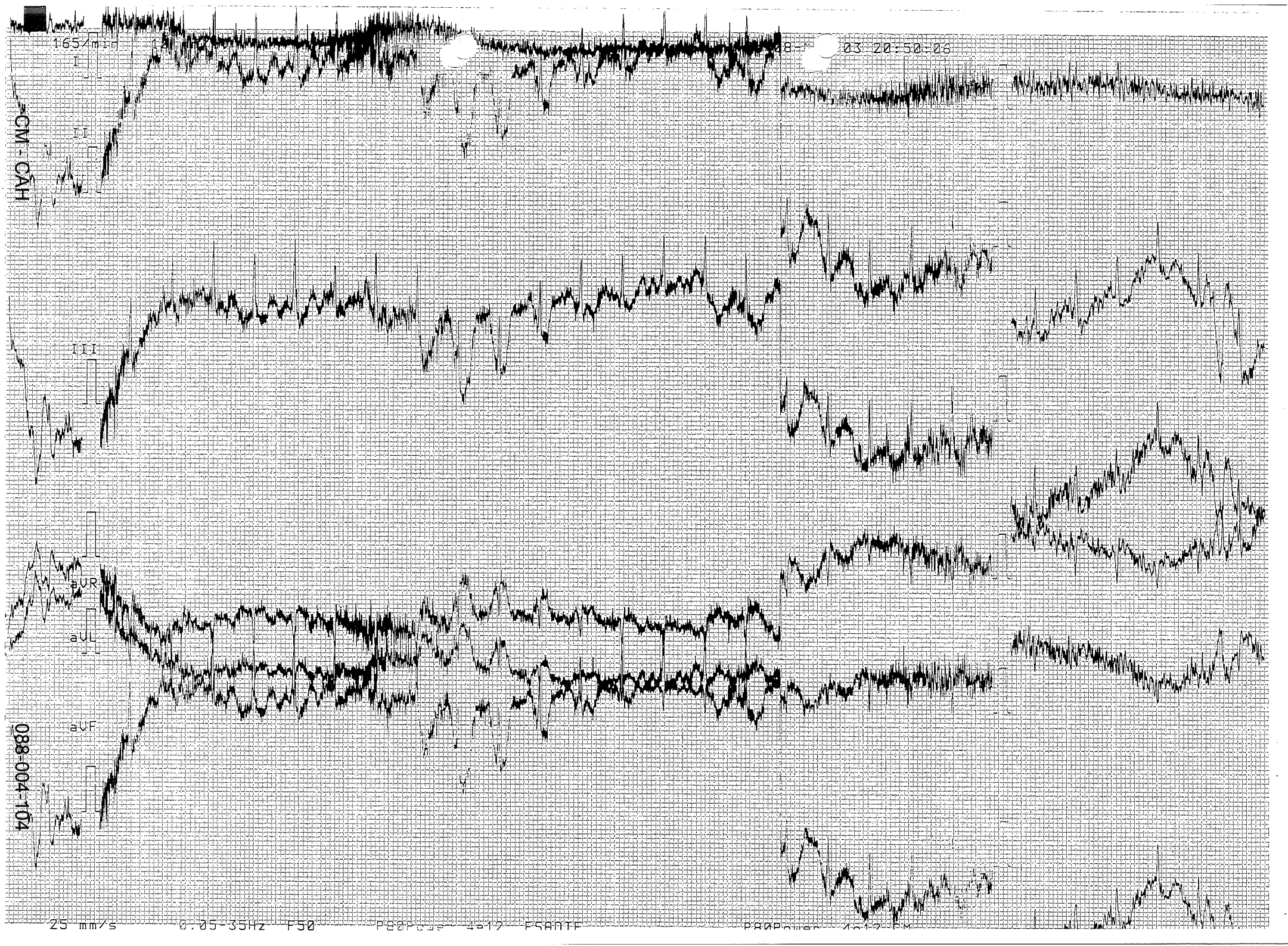
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III
aVR
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aVF
CM - CAH
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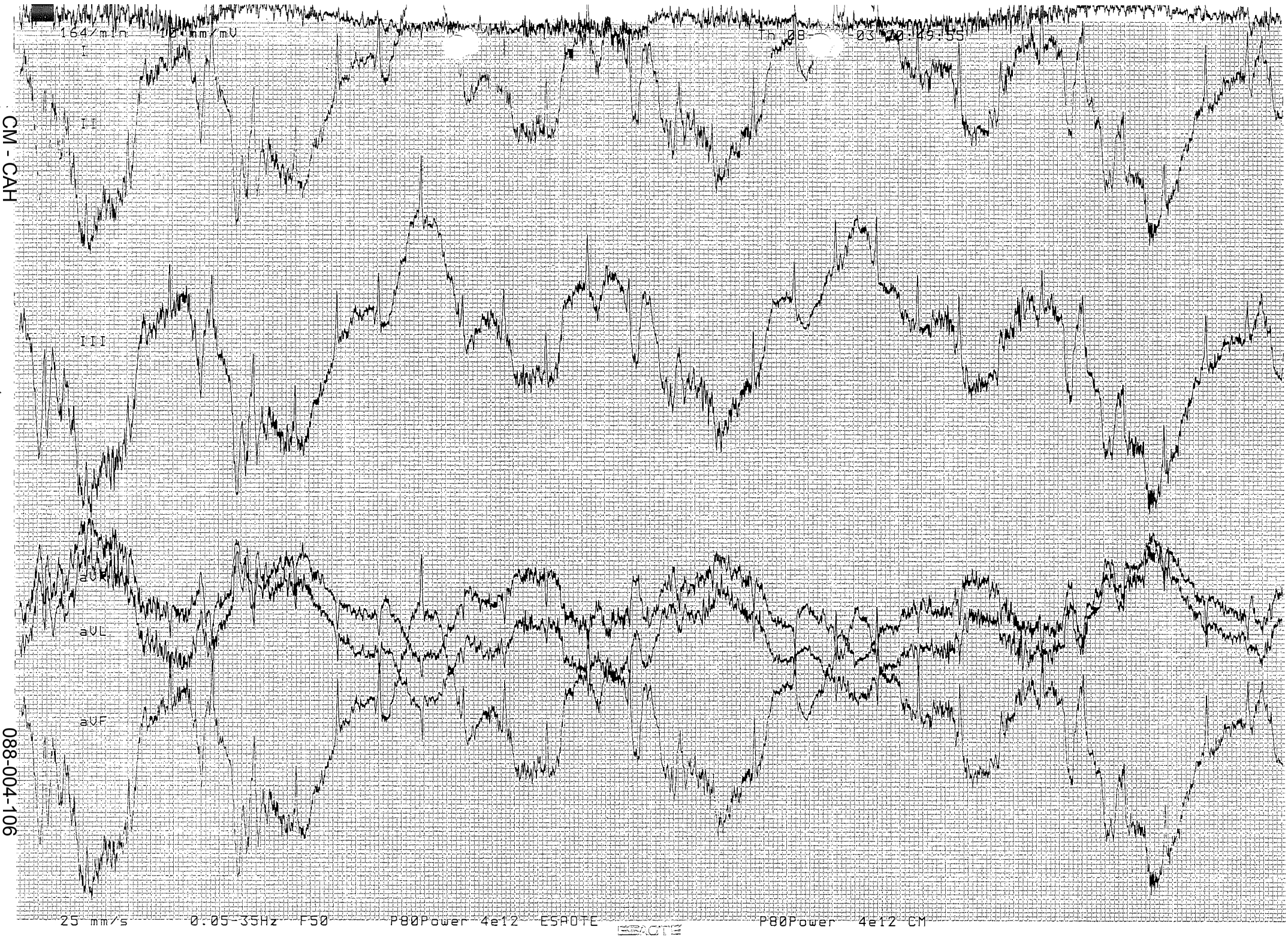
089-004-104

CM - CAH

088-004-105



CM - CAH

088-004-106

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

(Consent forms to be affixed to back of sheet)

12	
11	
10	
9	
8	
7	

CRAIGAVON AREA HOSPITAL

ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 90801
Doctor : DR W. MCCAUGHEY

Name : MITCHELL
Forename : CONOR
Clinic/Ward : INTENSIVE CARE UNIT
Address : [redacted]
Hosp No. : CAHB63929
D.O.B. : 12/10/1987

Apply label from the patient upwards

COAGULATION SCREEN

PT	16.6	SEC
A.P.T.T.	30.0	SEC
THROMBIN TIME	16.1	SEC
FIBRINOGEN	2.00	G/L
FDP	-	UG/ML

RVH.

EMATOLOGY CS	90801	SAMPLE DATE: 9/5/2003 08AM REPORT DATE: 09/05/2003Auth : GQ
HAEMATOLOGY CS	90005	SAMPLE DATE: 9/5/2003 REPORT DATE: 09/05/2003Auth : VA
HAEMATOLOGY ESR	80792	SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : MT
HAEMATOLOGY FBC	80834	SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : QC
HAEMATOLOGY FBC	90801	SAMPLE DATE: 9/5/2003 08AM REPORT DATE: 09/05/2003Auth : GQ
HAEMATOLOGY FBC		

CRAIGAVON AREA HOSPITAL

ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 90005
Doctor : DR PHILIP MURPHY

Name : MITCHELL
Forename : CONOR
Clinic/Ward : INTENSIVE CARE UNIT
Address : [redacted]
Hosp No. : CAHB63929
D.O.B. : 12/10/1987

COAGULATION SCREEN

PT	17.0	SEC
A.P.T.T.	36.3	SEC
THROMBIN TIME	21.0	SEC
FIBRINOGEN	1.50	G/L
FDP	-	UG/ML

RESULTS CHECKED

HAEMATOLOGY CS	90005	SAMPLE DATE: 9/5/2003 REPORT DATE: 09/05/2003Auth : VA
HAEMATOLOGY ESR	80792	SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : MT
HAEMATOLOGY FBC	80834	SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : QC
HAEMATOLOGY FBC	90801	SAMPLE DATE: 9/5/2003 08AM REPORT DATE: 09/05/2003Auth : GQ
HAEMATOLOGY FBC		

CRAIGAVON AREA HOSPITAL

ACC A/E

LABORATORY [redacted]

Lab Number : 80792
Doctor : MR C.R. FEE

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

TEST	RESULT	REFERENCE RANGE	UNITS
ESR(WEST)	-	(0 - 15)	mm/h
SAMPLE INSUFFICIENT			

HAEMATOLOGY ESR 80792 SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : MT

HAEMATOLOGY FBC 80834 SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : QC

HAEMATOLOGY FBC 90801 SAMPLE DATE: 9/5/2003 08AM REPORT DATE: 09/05/2003Auth : GQ

HAEMATOLOGY FBC [illegible]

CRAIGAVON AREA HOSPITAL ACC A/E

LABORATORY [redacted]

ICU

Lab Number : 80834
Doctor : MR C.~~R. FEE~~

CMA.

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

FULL BLOOD COUNT

HB	13.6	MCH	33.2	WBC	19.1	PLT	232
PCV	.396	MCHC	34.5	GR%	87.9		
RBC	4.11	RDW	12.4	LY%	8.06		
MCV	96.4			MONO%	4.05		
				EOS%	.03		
				BAS%	0		

HAEMATOLOGY FBC 80834 SAMPLE DATE: 8/5/2003 11AM REPORT DATE: 08/05/2003Auth : QC

HAEMATOLOGY FBC 90801 SAMPLE DATE: 9/5/2003 08AM REPORT DATE: 09/05/2003Auth : GQ

HAEMATOLOGY FBC

CRAIGAVON AREA HOSPITAL

ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 90801
Doctor : DR W. MCCAUGHEY

Name : MITCHELL
Forename : CONOR
Clinic/Ward : INTENSIVE CARE UNIT
Address : [redacted]
Hosp No. : CAHB63929
D.O.B. : 12/10/1987

Apply this label to all blood specimens

FULL BLOOD COUNT

HB	14.7	MCH	33.7	WBC	29.6	PLT	237
PCV	.415	MCHC	35.5	GR%	84.5		
RBC	4.37	RDW	12.8	LY%	8.65		
MCV	95			MONO%	6.73		
				EOS%	.075		
				BAS%	0		

RVH.

SAMPLE DATE: 9/5/2003 08AM
HAEMATOLOGY FBC 90801 REPORT DATE: 09/05/2003Auth : GQ

HAEMATOLOGY FBC

CRAIGAVON AREA HOSPITAL ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 90005
Doctor : DR PHILIP MURPHY

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **INTENSIVE CARE UNIT**
Address : [redacted]
Hosp No. : CAHB63929
D.O.B. : 12/10/1987

FULL BLOOD COUNT

HB	13.8	MCH	33.7	WBC	7.36	PLT	184
PCV	.383	MCHC	36	GR%	75.3		
RBC	4.1	RDW	12.5	LY%	22.1		
MCV	93.5			MONO%	2.39		
				EOS%	.169		
				BAS%	0		

SAMPLE DATE: 9/5/2003
HAEMATOLOGY FBC 90005 REPORT DATE: 09/05/2003Auth : VA

CM - CAH 088-004-112

CRAIGAVON AREA HOSPITAL

ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 1337
Doctor : DR W. MCCAUGHEY

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **INTENSIVE CARE UNIT**
Address : [redacted]
Hosp No. : CAHB63929
D.O.B. : 12/10/1987

Test	Result		Ref Range
Sodium	149*	mmol/L	(135 - 145)
Potassium	3.8	mmol/L	(3.5 - 5.1)
Chloride	119*	mmol/L	(98 - 108)
HCO3	18.7*	mmol/L	(24 - 32)
Urea	5.9	mmol/L	(3 - 7)
Serum Creatinine	65	umol/L	(60 - 120)
Albumin	37	g/L	(35 - 50)
Calcium	2.51	mmol/L	(2.1 - 2.6)
Corrected Calcium	2.58	mmol/L	(2.1 - 2.6)
Phosphate	0.33*	mmol/L	(0.79 - 1.50)
SERUM GLUCOSE	5.0	mmol/L	(4 - 7.8)
Magnesium	0.93	mmol/L	(0.75 - 1.05)

BIOCHEMISTRY	INTENSIVE CARE PROFILE	SAMPLE DATE: 09/05/2003 08.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	INTENSIVE CARE PROFILE	SAMPLE DATE: 09/05/2003 00.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	C-REACTIVE PROTEIN	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003
BIOCHEMISTRY	CALCIUM	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003
BIOCHEMISTRY	VALPROATE	SAMPLE DATE: 08/05/2003 21.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	UREA AND ELECTROLYTES	SAMPLE DATE: 08/05/2003 REPORT DATE: 08/05/2003
BIOCHEMISTRY	Serum Glucose	SAMPLE DATE: 08/05/2003 REPORT DATE: 09/05/2003

CRAIGAVON AREA HOSPITAL

ICU INTENSIVE CARE UNIT

LABORATORY [redacted]

Lab Number : 1317
Doctor : DR PHILIP MURPHY

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **INTENSIVE CARE UNIT**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

Test	Result		Ref Range
Sodium	139	mmol/L	(135 - 145)
Potassium	2.5*	mmol/L	(3.5 - 5.1)
Chloride	106	mmol/L	(98 - 108)
HCO3	12.3*	mmol/L	(24 - 32)
Urea	5.7	mmol/L	(3 - 7)
Serum Creatinine	54*	umol/L	(60 - 120)
Albumin	38	g/L	(35 - 50)
Calcium	2.42	mmol/L	(2.1 - 2.6)
Corrected Calcium	2.47	mmol/L	(2.1 - 2.6)
Phosphate	< 0.33*	mmol/L	(0.79 - 1.50)
SERUM GLUCOSE	7.9*	mmol/L	(4 - 7.8)
Magnesium	0.98	mmol/L	(0.75 - 1.05)

BIOCHEMISTRY	INTENSIVE CARE PROFILE	SAMPLE DATE: 09/05/2003 00.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	C-REACTIVE PROTEIN	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003
BIOCHEMISTRY	CALCIUM	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003
BIOCHEMISTRY	VALPROATE	SAMPLE DATE: 08/05/2003 21.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	UREA AND ELECTROLYTES	SAMPLE DATE: 08/05/2003 REPORT DATE: 08/05/2003
BIOCHEMISTRY	Serum Glucose	SAMPLE DATE: 08/05/2003 REPORT DATE: 09/05/2003

CRAIGAVON AREA HOSPITAL

ACC A/E

LABORATORY [redacted]

Lab Number : 1159
Doctor : MR C.R. FEE

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

Test	Result	Ref Range
C Reactive Protein	< 5.0 mg/L	(0 - 5)

SAMPLE EDTA CONTAMINATED??

BIOCHEMISTRY	C-REACTIVE PROTEIN	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003	
BIOCHEMISTRY	CALCIUM	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003	
BIOCHEMISTRY	VALPROATE	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003	21.00
BIOCHEMISTRY	UREA AND ELECTROLYTES	SAMPLE DATE: 08/05/2003 REPORT DATE: 08/05/2003	
BIOCHEMISTRY	Serum Glucose	SAMPLE DATE: 08/05/2003 REPORT DATE: 09/05/2003	

CM - CAH

088-004-115

CRAIGAVON AREA HOSPITAL ACC A/E

LABORATORY [redacted]

Lab Number : 1159
Doctor : MR C.R. FEE

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

B63929

Test	Result		Ref Range
Calcium	--	mmol/L	(2.1 - 2.6)
Albumin	45	g/L	(35 - 50)
Corrected Calcium	--	mmol/L	(2.1 - 2.6)

SAMPLE EDTA CONTAMINATED??

BIOCHEMISTRY	CALCIUM	SAMPLE DATE: 08/05/2003 REPORT DATE: 13/05/2003
BIOCHEMISTRY	VALPROATE	SAMPLE DATE: 08/05/2003 21.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	UREA AND ELECTROLYTES	SAMPLE DATE: 08/05/2003 REPORT DATE: 08/05/2003
BIOCHEMISTRY	Serum Glucose	SAMPLE DATE: 08/05/2003 REPORT DATE: 09/05/2003

CRAIGAVON AREA HOSPITAL

MAU MED ASSESSMENT UNIT

LABORATORY [redacted]

Lab Number : 1307
Doctor : DR PHILIP MURPHY

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **MED ASSESSMENT UNIT**
Address : [redacted]
Hosp No. : B63929
D.O.B. : 12/10/1987

Test	Result		Ref Range
Valproic Acid	67	mg/L	(50 - 100)

BIOCHEMISTRY	VALPROATE	SAMPLE DATE: 08/05/2003 21.00 REPORT DATE: 13/05/2003
BIOCHEMISTRY	UREA AND ELECTROLYTES	SAMPLE DATE: 08/05/2003 REPORT DATE: 08/05/2003
BIOCHEMISTRY	Serum Glucose	SAMPLE DATE: 08/05/2003 REPORT DATE: 09/05/2003

CRAIGAVON AREA HOSPITAL

ACC A/E

LABORATORY [redacted]

Lab Number : 1159
Doctor : MR C.R. FEE

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

Test	Result		Ref Range
Sodium	138	mmol/L	(135 - 145)
Potassium	--	mmol/L	(3.5 - 5.1)
Chloride	97*	mmol/L	(98 - 108)
Urea	7.8*	mmol/L	(3 - 7)
Serum Creatinine	57*	umol/L	(60 - 120)
HCO3	21.0*	mmol/L	(24 - 32)

SAMPLE EDTA CONTAMINATED??

SAMPLE DATE: 08/05/2003

BIOCHEMISTRY UREA AND ELECTROLYTES REPORT DATE: 08/05/2003

SAMPLE DATE: 08/05/2003

BIOCHEMISTRY Serum Glucose REPORT DATE: 09/05/2003

CRAIGAVON AREA HOSPITAL ACC A/E

I.C.U.

LABORATORY [redacted]

Lab Number : 1159
Doctor : MR C.R. FEE

Name : **MITCHELL**
Forename : **CONOR**
Clinic/Ward : **A/E**
Address : [redacted]
Hosp No. :
D.O.B. : 12/10/1987

Test	Result		Ref Range	
SERUM GLUCOSE	7.6	mmol/L	Fasting	4.0 - 7.0
			Non Fasting	4.0 - 7.8

KWC 12/5/03.

MAW

SAMPLE EDTA CONTAMINATED??

SAMPLE DATE: 08/05/2003
REPORT DATE: 09/05/2003

BIOCHEMISTRY Serum Glucose

CM CAH

088-004-119

HOSPITAL No.

ICU

MAL

CRAIGAVON AREA HOSPITAL - A/E

Lab Number	: 88007	Name	: MITCHELL CONOR
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987 Sex : M
Specimen Type	: Blood Culture	Hosp No	:
Doctor	: MR C.R. FEE	Address	: [redacted]
Destination	: A/E		:
Hospital	: CRAIGAVON AREA HOSPITAL		:
			:
Clin details	: UNWELL CHILD		
	:		
Cur. Antibiotic	:		

CULTURE : No growth after 7 days

[redacted]

Apply forms from the bottom upwards

(Consent forms to be affixed to back of sheet)

D.O.B.

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

CRAIGAVON AREA HOSPITAL - INTENSIVE CARE UNIT

Lab Number	: 93013	Name	: MITCHELL CONOR		
Sample Date/Time	: 09/05/2003	DOB	: 12/10/1987	Sex	: M
Specimen Type	: Sputum trap	Hosp No	: CAHB63929		
Doctor	: DR PHILIP MURPHY	Address	: [redacted]		
Destination	: INTENSIVE CARE UNI		:		
Hospital	: CRAIGAVON AREA HOSPITAL		:		
			:		
Clin details	: RESPIRATORY ARREST				
	: H/O CEREBRAL PALSY				
Cur. Antibiotic	: CIPROXIN , ACYCLOVIR				
APPEARANCE	: Mucoid				
	:				

MICROSCOPY

CULTURE : Oral-pharyngeal flora isolated

[redacted]

CRAIGAVON AREA HOSPITAL - INTENSIVE CARE UNIT

Lab Number	: 96206	Name	: MITCHELL CONOR		
Sample Date/Time	: 09/05/2003	DOB	: 12/10/1987	Sex	: M
Specimen Type	: MRSA SCREEN	Hosp No	: CAHB63929		
Doctor	: DR PHILIP MURPHY	Address	: [redacted]		
Destination	: INTENSIVE CARE UNI		:		
Hospital	: CRAIGAVON AREA HOSPITAL		:		
			:		
Clin details	:				
Infection Site	:				
Cur. Antibiotic	:				

CULTURE :

NO MRSA ISOLATED

Site(s)

Nasal	NO MRSA
Axilla	NO MRSA
Groin	NO MRSA

RMC

[redacted]

Apply forms from the bottom upwards

CRAIGAVON AREA HOSPITAL - INTENSIVE CARE UNIT

Lab Number	: 91218	Name	: MITCHELL CONOR
Sample Date/Time	: 09/05/2003	DOB	: 12/10/1987 Sex : M
Specimen Type	: Catheter Urine	Hosp No	: CAHB63929
Doctor	: DR PHILIP MURPHY	Address	: [redacted]
Destination	: INTENSIVE CARE UNI		:
Hospital	: CRAIGAVON AREA HOSPITAL		:
	:		:
Clin details	:		
	:		
Cur. Antibiotic	: CIPROXIN , ACYCLOVIR		

MICROSCOPY / H.P.F.

Not significant

CULTURE : Not significant<10,000 Orgs/ml

[redacted]

Apply forms from the bottom upwards

CRAIGAVON AREA HOSPITAL - A/E

Lab Number	:	88007	Name	:	MITCHELL CONOR
Sample Date/Time	:	08/05/2003	DOB	:	12/10/1987 Sex : M
Specimen Type	:	Blood Culture	Hosp No	:	
Doctor	:	MR C.R. FEE	Address	:	[redacted]
Destination	:	A/E		:	
Hospital	:	CRAIGAVON AREA HOSPITAL		:	
				:	
Clin details	:	UNWELL CHILD			
	:				
Cur. Antibiotic	:				

CULTURE : No growth after 2 days

Apply forms from the bottom upwards

[redacted]

CRAIGAVON AREA HOSPITAL - A/E

Lab Number	: 88007	Name	: MITCHELL CONOR
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987 Sex : M
Specimen Type	: Blood Culture	Hosp No	:
Doctor	: MR C.R. FEE	Address	: [redacted]
Destination	: A/E		:
Hospital	: CRAIGAVON AREA HOSPITAL		
Clin details	: UNWELL CHILD		
	:		
Cur. Antibiotic	:		

CULTURE : No growth after 2 days

[redacted]

Apply forms from the bottom upwards

CRAIGAVON AREA HOSPITAL - MED ASSESSMENT UNIT

Lab Number	: 81112	Name	: MITCHELL CONOR
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987 Sex : M
Specimen Type	: Urine	Hosp No	:
Doctor	: DR PHILIP MURPHY	Address	: [redacted]
Destination	: MED ASSESSMENT UNI		:
Hospital	: CRAIGAVON AREA HOSPITAL		:
			:
Clin details	:		
	:		
Cur. Antibiotic	:		

MICROSCOPY / H.P.F. CULTURE : Not tested

Pus cells
Red cells
Organisms
Epith.cells

COMMENT(S) : SPECIMEN UNLABELLED PLEASE REPEAT

[redacted]

Apply forms from the bottom upwards

Lab Number	: 81227	Name	: MITCHELL CONOR		
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987	Sex	: M
Specimen Type	: Mid Stream Urine	Hosp No	: CAHB63929		
Doctor	: DR PHILIP MURPHY	Address	: [redacted]		
Destination	: MED ASSESSMENT UNI		:		
Hospital	: CRAIGAVON AREA HOSPITAL		:		
	:		:		
Clin details	:				
	:				
Cur. Antibiotic	: CIPROXIN				

MICROSCOPY / H.P.F. CULTURE : Not significant<10,000 Orgs/ml

Pus cells	Not seen
Red cells	3
Organisms	Not seen
Epith.cells	Not seen

[redacted]

CRAIGAVON AREA HOSPITAL - MED ASSESSMENT UNIT

Lab Number	: 81227	Name	: MITCHELL CONOR		
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987	Sex	: M
Specimen Type	: Mid Stream Urine	Hosp No	: CAHB63929		
Doctor	: DR PHILIP MURPHY	Address	: [redacted]		
Destination	: MED ASSESSMENT UNI		:		
Hospital	: CRAIGAVON AREA HOSPITAL		:		
	:		:		
Clin details	:				
	:				
Cur. Antibiotic	: CIPROXIN				

MICROSCOPY / H.P.F. CULTURE : Not significant<10,000 Orgs/ml

Pus cells	Not seen
Red cells	3
Organisms	Not seen
Epith.cells	Not seen

Apply forms from the bottom upwards

[redacted]

CRAIGAVON AREA HOSPITAL - MED ASSESSMENT UNIT

Lab Number	: 81227	Name	: MITCHELL CONOR		
Sample Date/Time	: 08/05/2003	DOB	: 12/10/1987	Sex	: M
Specimen Type	: Mid Stream Urine	Hosp No	: CAHB63929		
Doctor	: DR PHILIP MURPHY	Address	: [redacted]		
Destination	: MED ASSESSMENT UNI		:		
Hospital	: CRAIGAVON AREA HOSPITAL		:		
			:		
Clin details	:				
	:				
Cur. Antibiotic	: CIPROXIN				

MICROSCOPY / H.P.F.

Pus cells	Not seen
Red cells	3
Organisms	Not seen
Epith.cells	Not seen

CULTURE : Not significant<10,000 Orgs/ml

Apply forms from the bottom upwards

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

(Consent forms to be affixed to back of sheet)

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CRAIGAVON AREA HOSPITAL

DEPARTMENT OF RADIO DIAGNOSIS

Film No.:	Physician or Surgeon:	Date:
31945/03	DR C MCALLISTER	08/05/2003
Patient's Name:	**Address:**	**Ward:**
MITCHELL CONOR	[redacted]	O.P: INTENSIVE CARE UNIT
Region Examined:		**Age:**
CHEST PORTABLE		12/10/1987

There are no significant areas of consolidation identified.

Date:	Region Examined:
Reported Date 13/06/2003	CHEST PORTABLE
13/06/2003 Dr C Brice	

Date:	Region Examined:
Reported Date 12/05/2003	CT BRAIN ADULT
12/05/2003 Dr P F Rice	

WM0074N

WM0074N

DKM Ref: 17969

WMZ5679

CM - CAH

088-004-130

REPORT MOUNT SHEET

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HOSPITAL No.

D.O.B.

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CRAIGAVON AREA HOSPITAL

DEPARTMENT OF RADIO DIAGNOSIS

7599

Film No.:	Physician or Surgeon:	Date:
31937/03	Dr.P.MURPHY	08/05/2003
Patient's Name:	**Address:**	**Ward:**
MITCHELL CONOR	[redacted]	O.P: Medical Admission Un
Region Examined:		**Age:**
CT BRAIN ADULT		12/10/1987

CT BRAIN ADULT:

The scans were performed without and thereafter with intra-venous contrast enhancement.

This is an abnormal examination.

There are no old CT scans available for comparison.

There is a large left sided por-encephalic cyst. There is overlying thinning of the skull vault indicating the

Date:	Region Examined:
Reported Date 12/05/2003	CT BRAIN ADULT

12/05/2003 Dr F F Rice

WM0074N

DKM Ref: 17869

REPORT MOUNT SHEET

SURNAME

NAME

HOSPITAL No.

D.O.B.

AFFIX PATIENT'S IDENTIFICATION LABEL HERE

(Consent forms to be affixed to back of sheet)

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7599

CRAIGAVON AREA HOSPITAL

DEPARTMENT OF RADIO DIAGNOSIS

Film No.:	Physician or Surgeon:	Date:
31937/03	Dr.P.MURPHY	08/05/2003
Patient's Name:	**Address:**	**Ward:**
MITCHELL CONOR	[redacted]	O.P: Medical Admission Un
Region Examined:		**Age:**
CT BRAIN ADULT		12/10/1987

chronic nature of this abnormality. There is a smaller right sided por-encephalic cyst. A significant proportion of the supra-tentorial region is of CSF density and there is markedly reduced cerebral cortex. In the basal cistern region, high density material is noted which also extends over the tentorium cerebelli. These appearances suggest subarachnoid blood. The basal cisterns appear tight. High density is noted in the left anterior cranial fossa (image 12) and I feel that this most likely represents partial volume averaging through the left frontal sinus region. I do not think this represents an area of

Date:	Region Examined:
Reported Date 12/05/2003	CT BRAIN ADULT

12/05/2003 Dr P F Rice

DKM Ref:17869

WM0074N

REPORT MOUNT SHEET

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HOSPITAL No.

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CRAIGAVON AREA HOSPITAL

DEPARTMENT OF RADIO DIAGNOSIS

-7599

Film No.: 31937/03	Physician or Surgeon: Dr.P.MURPHY	Date: 08/05/2003
Patient's Name: MITCHELL CONOR	Address: [redacted]	Ward: I.C.U. O.P: ~~Medical Admission Un~~
Region Examined: CT BRAIN ADULT	B63929	Age: 12/10/1987

haemorrhage.

Conclusion: Long history of cerebral palsy noted. Subarachnoid blood is present within the basal cisterns and on the tentorium cerebelli. The images have been image linked to the RVH.

Date:	Region Examined:
Reported Date 12/05/2003 12/05/2003 Dr P F Rice	CT BRAIN ADULT

WM0074N

DKM Ref: 17969

CM - CAH

088-004-133

RADIOMETER ABL 700 S

ABL725 Intensive Care Unit
PATIENT REPORT Syringe - S 195uL Sa

Identifications

Patient ID	SIOBHAN
Patient Last Name	
Patient First Name	
Sample type	Not specified
temp	37.0 °C

Blood Gas Values

pH	7.450		[7.350 - 7.450]
pO_2	12.7	kPa	[10.0 - 15.0]
↓ pCO_2	4.08	kPa	[4.50 - 6.50]

Oximetry Values

↑ $ctHb$	14.3	g/dL	[12.0 - 14.0]
sO_2	98.2	%	[92.0 - 100.0]
FO_2Hb	95.9	%	[-]
$FCOHb$	1.6	%	[-]
$FHHb$	1.8	%	[-]
$FMetHb$	0.7	%	[-]
Hct_c	44.0	%	

Electrolyte Values

cK^+	3.8	mmol/L	[3.5 - 4.5]
↑ cNa^+	148	mmol/L	[133 - 146]
↑ cCa^{2+}	1.38	mmol/L	[1.05 - 1.30]
↑ cCl^-	117	mmol/L	[96 - 106]
Anion Gap_c	10.6	mmol/L	
$AnionGap,K^+_c$	14.4	mmol/L	

Metabolite Values

$cGlu$	4.9	mmol/L	[3.6 - 5.6]
↑ $cLac$	2.5	mmol/L	[0.2 - 1.0]

Temperature Corrected Values

$pH(T)$	7.450	
$pO_2(T)$	12.7	kPa
$pCO_2(T)$	4.08	kPa

Oxygen Status

ctO_{2c}	19.4	Vol%
$p50_c$	3.27	kPa

Acid Base Status

$cBase(Ecf)_c$	-2.5	mmol/L
$cHCO_3^-(P,st)_c$	23.1	mmol/L

Notes

pCO_2	Measured value below reference range but within the critical limits
cCl^-	Measured value above reference range but within the critical limits
$cLac$	Measured value above reference range but within the critical limits
cCa^{2+}	Measured value above reference range but within the critical limits
cNa^+	Measured value above reference range but within the critical limits
$ctHb$	Measured value above reference range but within the critical limits

Printed 08:35 09/05/03

For Anaesthetic and Operation
Discharge against Advice, Post

ration,